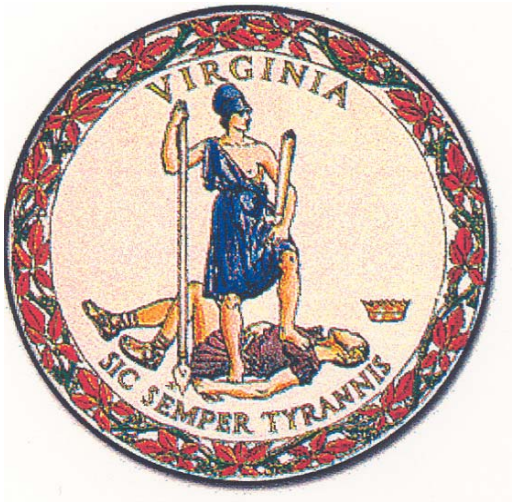

REVIEW OF
COMMUNITY SERVICES BOARD
MENTAL RETARDATION CASE MANAGEMENT
SERVICES FOR ADULTS

Prepared by:
Office of the Inspector General
For Mental Health, Mental Retardation
& Substance Abuse Services

James W. Stewart, III
Inspector General

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Office of the Inspector General
Review of Mental Retardation Case Management Services for Adults

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Section I

Office of the Inspector General
Review of Mental Retardation Case Management Services for Adults

Executive Summary

The Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services (OIG) conducted a review of the statewide system of community services board (CSB) mental retardation case management services for adults during May and June of 2007. Case management was selected for review because it is considered an essential service for persons with mental retardation and the provision of this service is mandated in the VA Code §37.2-500. Approximately 13,083 individuals were receiving adult mental retardation case management at the time of this review.

To assure that the review focused on current issues, the OIG invited the contribution of ideas from a wide range of stakeholders including public and private community providers and the staff of the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS). The basis for the review was five Quality Statements for Case Management Services that were developed by the OIG (Attachment A). The review included a survey of all 40 CSBs and visits by OIG inspectors to a random sample of 28 of the CSBs. During the site visits, interviews were conducted with 262 case managers, 57 division directors and case management supervisors. 275 service recipient case records were reviewed at the sample CSBs. After the site visits, 92 family members and 26 private residential service providers were interviewed.

Quality of Care Findings and Recommendations

A. Person-Centered Services

The hallmark indicator of quality in case management services is the degree to which these services are designed, selected, and directed by the person receiving services.

Quality of Care Finding A.1: While case managers state that the persons they serve have a significant role in developing their own service plans, case management records only partially reflect this goal.

> **Quality of Care Recommendation A.1:** It is recommended that DMHMRSAS, with the involvement of DMAS, CSBs, persons served and their families, develop a model case management service planning system and format that is person-centered and meets all regulatory requirements.

Quality of Care Finding A.2: Neither case managers nor supervisors expressed strong dissatisfaction or disapproval of the term case management.

No Recommendation

B. Coordination of Services

Case management coordinates needed supports in a comprehensive manner, affording the person and his or her family the greatest possible choice among providers and services.

Quality of Care Finding B.1: Mental retardation case management activities appropriately focus on linkage and coordination of services.

No recommendation

Quality of Care Finding B.2: Persons receiving mental retardation case management services face severe shortages of core services needed for successful integration and independence in the community – residential services options, day support and employment options, reliable transportation, timely access to mental health services (therapy, psychiatric medicine), and crisis intervention options. Choice is limited by scarcity of varied service options.

Quality of Care Recommendation B.2: It is recommended that DMHMRSAS and DMAS continue to work cooperatively to seek avenues to steadily increase the capacity of core support services in the community – residential services, day support and employment options, reliable transportation, timely access to mental health services and crisis intervention options.

Quality of Care Finding B.3: Case managers encounter significant problems in providing or securing the therapy, supportive counseling, and psychiatric services needed by the persons they serve who have dual diagnoses of mental retardation and mental illnesses and/or behavioral challenges.

Quality of Care Recommendation B.3.a: It is recommended that each CSB review current programming in mental health and mental retardation services to identify gaps in programming to address the needs of individuals with mental retardation who have co-occurring mental illness and/or challenging behaviors. It is further recommended that each CSB develop and implement a plan to address the identified gaps.

Quality of Care Recommendation B.3.b: It is recommended that DMHMRSAS compile a statewide description of programming needs identified in the local plans that cannot be met with existing resources and seek funding to help address these needs.

Quality of Care Recommendation B.3.c: It is recommended that DMHMRSAS establish a statewide policy that clarifies the safety net role of the training centers in providing emergency services to consumers with mental retardation who demonstrate severe behavior management problems or may have a severe mental illness. This policy should state clearly

what conditions are appropriate for emergency admission, which are not, and when it is appropriate for an individual with either of these conditions to be admitted to a state mental health hospital.

Quality of Care Finding B.4: A majority of families and authorized representatives of persons served by CSB case management report that they and their family members experience adequate communication, involvement, and choice in development of their family members' service plans and selection of community supports.

No recommendation

Quality of Care Finding B.5: When a person's ability to choose is limited, and professional and legal judgment suggests a form of substitute consent is needed, it is difficult to find qualified persons to serve as authorized representatives and guardians.

Quality of Care Recommendation B.5: It is recommended that DMHMRSAS continue to monitor needs as this program progresses.

Quality of Care Finding B.6: Persons who are served by mental retardation case management are generally unable to gain access to their case managers after normal business hours and on weekends, when they must contact the CSB's emergency services program.

Quality of Care Recommendation B.6.a: It is recommended that CSB's investigate the use of systems by which persons can reach their own case managers or a knowledgeable backup in times of crisis so that they might speak to someone they know and trust rather than routinely having to deal solely with the emergency services system after regular business hours.

Quality of Care Recommendation B.6.b: It is recommended that CSBs assure that all parties that may have reason to contact family members and/or authorized representatives in emergency situations have access to accurate phone numbers.

Quality of Care Finding B.7: Efforts by CSBs to identify needs and to help people transition from public school special education programs into community services for adults vary greatly among CSBs.

No Recommendation

C. Consumer/Case Manager Connection

Case managers and the persons they serve share a constructive interpersonal helping connection that fosters trust, cooperation, and support for each person's pathway to greater independence and self determination.

Quality of Care Finding C.1: Case managers are committed to the persons they serve and their commitment and respect is noted and appreciated by family members.

No recommendation

Quality of Care Finding C.2: While a majority of case managers have tenure on the job that enables continuity in the relationships with those they serve, a significant minority of staff (26%) have been on the job 12 months or less which results in disruption to the supportive relationship. Turnover varies significantly among the 40 CSBs.

No recommendation

D. Case Management Activity and Outreach

Case management is a vigorous, active service, with frequent face-to-face and collateral contacts provided at a level sufficient to assure positive outcomes, guided by the preferences of the person receiving services.

Quality of Care Finding D.1: The frequency of face-to-face contact by CSB mental retardation case managers with the persons they serve averages about twice a quarter (2.2) or just under nine per year (8.8) which is more than the minimum required by Medicaid.

Quality of Care Recommendation D.1.a: It is recommended that CSBs assess what changes in administrative requirements, case load size and staffing levels are necessary to increase the level of face-to-face activity case managers are able to have with the persons they serve and to implement these changes.

Quality of Care Finding D.2: Most case management visits to persons served take place out in the community.

No Recommendation

Quality of Care Finding D.3: While little information is available regarding national standards to which Virginia caseloads can be compared, many family members, CSB case managers and supervisors, and private providers indicate that increased face to face contact by case managers with those they serve is needed and that caseload size serves as a barrier to adequate contact.

Quality of Care Recommendation D.3.a: It is recommended that DMHMRSAS study the advisability of establishing a caseload standard for CSB case managers who work with individuals with mental retardation and establish such a standard if it is determined advisable.

Quality of Care Recommendation D.3.b: If it is determined that a caseload standard is advisable and if caseload levels at CSBs significantly exceed this standard, it is recommended that DMHMRSAS seek additional resources to lower the average caseload.

Quality of Care Finding D.4: Case management service recipients have the same access to and receive the same level of case management service regardless of eligibility for Medicaid as a payment source. However, Medicaid recipients do have greater access to other services such as mental retardation support services, transportation, affordable medications and outpatient services.

Quality of Care recommendation B.2 addresses the need for expanded community service availability

E. Case Manager Preparation and Support

Case managers must have knowledge, skills, and training specific to the wide range of tasks a case manager must provide. Case management is an essential service and its providers must be supported and recognized as core mental retardation professionals.

Quality of Care Finding E.1: Case managers and supervisors have appropriate education levels and experience for their positions.

No recommendations

Quality of Care Finding E.2: Case managers receive little training in topics specifically related to case management. Preparation and certification of the skills and abilities of case managers vary among CSBs, and are rarely formally documented.

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Quality of Care Recommendation E.2.a: It is recommended that DMHMRSAS initiate a collaborative effort with CSBs and consumers to develop a model training curriculum for mental retardation case managers and that this program be made available to all CSBs.

Quality of Care Recommendation E.2.b: It is recommended that DMHMRSAS and DMAS, with the involvement of CSBs, study the value of developing certification standards for mental retardation case managers.

Quality of Care Finding E.3: Administrative and documentation requirements consume an inordinate amount of staff time (estimated by case managers at 60.3%) and cost, interfering with or reducing service provision rather than supporting it.

Quality of Care Recommendation E.4: It is recommended that DMHMRSAS, DMAS, and CSBs review and amend their respective regulations, documentation requirements, and inspection procedures to seek ways to streamline, standardize, and minimize data and record keeping requirements in an effort to allow case managers to maximize the amount of time they are available to the persons they serve.

Quality of Care Finding E.5: Salaries for CSB case managers at some CSBs are very low. This contributes to staff turnover that interferes with continuity of care.

Quality of Care Recommendation E.5: It is recommended that each CSB conduct a review to determine if current salary ranges for case managers are having any negative impact on continuity of care for persons who receive case management services and develop strategies to address any problems that are identified.

Section II

Background of the Study

About the Office of the Inspector General

The Office of the Inspector General (OIG) is established in the VA Code § 37.2-423 to inspect, monitor and review the quality of services provided in the facilities operated by the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) and providers as defined in VA Code § 37.2-403. This definition includes all providers licensed by DMHMRSAS including community services boards (CSB) and behavioral health authorities (BHA), private providers, and mental health treatment units in Department of Correction facilities. It is the responsibility of the OIG to conduct announced and unannounced inspections of facilities and programs. Based on these inspections, policy and operational recommendations are made in order to prevent problems, abuses and deficiencies and improve the effectiveness of programs and services. Recommendations are directed to the Office of the Governor, the members of the General Assembly and the Joint Commission on Healthcare.

Selection of Adult Mental Retardation Case Management for Review

Mental retardation case management services for adults was selected by the OIG for review for the following reasons:

- The provision of case management by Virginia's CSBs is mandated in the VA Code §37.2-500. It is one of only two mandated services for CSBs. The other mandated service is emergency services.
- Case management is required and defined by Virginia Mental Health, Mental Retardation and Substance Abuse Services State Board policy, performance contract, discharge planning protocols, and continuity of care policies.
- Although case management is considered an essential service for persons with mental retardation and is provided across the nation in most communities, great variations in service models and types of case management are seen in professional literature and in practice. There has not been a review of case management services in Virginia.
- While CSBs are mandated to provide case management, who must receive case management is less clear. Screening and eligibility standards for case management may differ among the CSBs.
- There is a widespread impression that caseload sizes for CSB case managers are significantly larger than desirable for good services to consumers. Actual caseload sizes among CSBs are not known.
- Self-determination and choice have been identified by DMHMRSAS as critical principles to guide the mental retardation service delivery system. It is not known to what degree these values are reflected in the provision of case management services.
- Concern exists among private providers of residential and day support services, that CSB case managers, sometimes representing agencies that also provide residential and day

support services may favor certain providers or their own CSB-offered services, thereby not ensuring full and free choice among providers for the persons and families they serve.

- Concern exists that there may be frequent turnover of case managers, which if true, would interfere with the establishment of effective working relationships between staff and consumers and decrease the effectiveness of case management services.
- Concern exists that the lack of adequate support services such as residential and day support services prevents case managers and consumers from developing individual plans of care that will adequately address the identified needs.
- Some advocates express disapproval that the service is called "case management," noting that persons are not "cases" to be managed and that this term does not reflect person-first language.
- Since 1991, the Department of Medical Assistance Services (DMAS) has provided a dedicated source of reimbursement for Targeted Case Management (TCM) for those who meet the eligibility requirements for Medicaid and for this service. Some portion of adults with mental retardation do not qualify for Medicaid. The degree to which those without Medicaid have access to case management services is unknown.
- The OIG completed an extensive review of MH Case Management in 2006 (Report # 128-06). Many stakeholders expressed interest in a companion review to assess mental retardation case management.

Design of the Review

The design of the review included an extensive literature search of indicators of quality in adult mental retardation case management services, as seen by persons who receive such services, program experts, academics, standard-setting organizations, family members, and advocates. In addition, and in the fashion of previous OIG studies, input was sought from a wide variety of Virginia providers and stakeholders in both formal and informal settings.

Input was sought from the leadership committee of the Virginia Association of Community Services Boards (VACSB) Mental Retardation Services Council on April 13, 2007 and from the overall Council on May 4. The Advisory Consortium on Intellectual Disabilities, a widely representative advisory group to DMHMRSAS, provided input on May 20. Input to the design of the review was received from DMHMRSAS leadership and the Office of Mental Retardation. Leaders of Virginia's private residential provider organizations were also provided opportunities to advise on the focus and issues to be addressed in the review. Input was also provided by a conference call with CSB executive directors, mental retardation services directors, case management directors and case managers on April 26.

The process of literature review and input provided a basis for the development of the following five mental retardation case management quality statements and a subset of 27 more specific indicators. See a complete list of quality statements and indicators in Attachment A.

1. Case management services are person-centered and person-driven.
2. Case management coordinates needed supports in a comprehensive and efficient manner, affording the person and his or her family the greatest possible choice among providers and services.

3. Case managers and the persons they serve share a constructive interpersonal helping connection that fosters trust, cooperation, and support for each person's pathway to greater independence and self determination.
4. Case management is an active, positive service that reaches out to persons and provides continuing, active supports.
5. Case managers are qualified, well prepared, and supported in their roles.

Much of the latest literature and discussion by professionals and advocates now makes use of the term intellectual disabilities instead of mental retardation. However, as use of the term intellectual disabilities is not yet widely established in Virginia, this review has used the term mental retardation.

Development of survey instruments

OIG staff developed structured interview instruments that addressed each of the indicators in the quality statements, many from more than one point of view. Where possible, these questionnaires were based on tools that had been used before by the OIG in other studies of Virginia services. The design of this review is substantially similar to the 2006 mental health case management review, and some of that review's procedures, quality measures, and instruments were modified for this study.

The record review instrument and portions of the review process were field tested at the Portsmouth CSB on May 4, 2007. Portsmouth was not included in the sample for site visits. All survey questionnaires and checklists can be found in Appendix J in the version of the report that is located on the OIG website (www.oig.virginia.gov).

Process of the review

There were three main components of the review:

- A self-administered email survey of all 40 Virginia CSBs that assessed caseloads, staffing, structure, service design, salaries, and other factors;
- Site visits to a large and representative sample of 28 CSBs (70% of all CSBs). This sample covered all areas of the state, all types of CSBs, and included CSBs that collectively serve 82% of the population of Virginia. Site visits consisted of record reviews, staff interviews, and supervisor interviews;
- Telephone interviews with stakeholders. This included 92 families or authorized representatives of persons served by the sample of CSBs visited, and a random sample of 26 private residential providers (14.4% of the 180 private residential providers).
- While an important source of feedback about case management services is service users themselves, the time and resources needed to obtain input from a representative sample of persons with a wide range of intellectual and communication challenges were not available for this review.

Each CSB in the sample received an email notification from the OIG approximately five days in advance of the selected site visit date. This message: 1) announced the date of the inspection; 2) described the schedule for the day; 3) provided guidance to the CSB on selection of records for review; and 4) requested the presence of all MR case managers, except when such attendance would constitute a significant inconvenience or interruption of services. All visits were completed in a single day, except for the Fairfax-Falls Church CSB, which required a two-day visit. All of the CSB inspections were conducted by a single inspector for each site. John Pezzoli, Jim Stewart, and part-time consulting staff Jonathan Weiss and Ann White comprised the site visit team. John Pezzoli served as Project Manager for this review. Pat Pettie coordinated data entry and data analysis, working with Cameron Glenn.

Site visits began with interviews of the case management unit supervisor and the division director who oversee case management services. Case records were then reviewed. The OIG inspector selected a sample of records from a batch of records that had been gathered by the CSB in advance using criteria provided by the OIG. Selected records included a mixture of Medicaid Waiver, Medicaid Targeted Case Management and non-Medicaid persons, active and inactive or monitoring cases, and included a sample of records from each case manager interviewed. At the majority of CSBs eight active and five inactive records were reviewed. Larger samples were drawn for CSBs with significantly larger overall numbers of persons receiving case management services.

Group interview sessions were then held with case managers, usually around eight persons per group. In the group interviews, OIG staff explained pencil and paper survey forms and then supervised the private and anonymous completion of the forms by those in each group. After the questionnaires were completed and collected, the OIG staff led group discussions regarding case management related issues with the case managers.

The following summarizes the scope of the statewide review of mental retardation case management services:

- 40 CSBs completed the Survey of Adult Mental retardation Case Management Services.
- 262 case managers were interviewed.
- 275 active service recipient case records were reviewed; 65 inactive or monitoring cases were reviewed.
- 57 division directors and case management supervisors were interviewed.
- 92 family members or authorized representatives were interviewed.
- Representatives of 26 private providers of residential services were interviewed.
- All five DMHMRSAS operated training centers were surveyed regarding case management activity by the CSBs.

Section III

Brief Description of Service Delivery System

Number of Individuals Receiving Case Management

The OIG surveyed all 40 CSBs to collect information about the total number of persons receiving CSB mental retardation case management services throughout Virginia.

- CSBs reported serving 14,497 persons with mental retardation.
- Of this number, 13,083, or 90% percent were receiving adult mental retardation case management services. The differences are mostly accounted for by the exclusion of children from this study. Children's case management will be addressed along with other services in an upcoming OIG review.
- From the data available for this review, it is not possible to accurately estimate the percentages of these persons who have Medicaid or other funding specifically dedicated to support case management and those who do not have any dedicated case management funding. The data that are available suggest that approximately 12% of those receiving case management services do not have Medicaid.

Attachment B provides information about the total number of persons receiving CSB mental retardation case management by individual CSB.

Models for Delivering Case Management Services

Through surveys and interviews with service directors and case management supervisors, the OIG obtained information about the structures and protocols used by CSBs to deliver mental retardation case management services to adults.

Case management team structures

- 33 of the 40 CSBs (82.5%) operate one or more dedicated mental retardation case management teams. In these arrangements, only mental retardation case management services are offered and the team is not integrated with mental health case management. This is the predominant structure for delivering case management services.
- Five CSBs operate case management service units that include both mental retardation and mental health case managers on the same service team, though each staff member specializes in one service or the other. These five CSBs include: Goochland-Powhatan, New River Valley, Northwestern, Rappahannock Area, and Region Ten.
- Two CSBs (Rockbridge and Southside) report that they use fully integrated MH-MR case management with the same staff members providing both types of services.

Caseload weighting and tiers of service

- 26 CSBs (65%) have organized case management into tiers of service based on severity of need or level of functioning, with reduced staff-to-individual ratios for persons with greater severity of need.
    - Most persons receiving case management services from CSBs require *active* case management, a level of case management that meets Medicaid targeted case management (TCM) standards – not less than one face-to-face contact every 90 days, one other contact every 30 days. This service status is the principal focus of this review.
    - Persons with less intensive case management needs receive *inactive* case management (also called monitoring, tracking, or follow along), which typically calls for annual contacts, with more frequent responses when requested or needed.
        - OIG inspectors reviewed a random selection of 65 inactive cases at the CSBs in the sample that use this service category.
        - Persons receiving inactive case management included those individuals currently residing in state mental retardation facilities, children who are identified as future clients of CSBs, but now currently enrolled in public school education, or adults in the community who do not need or want active case management at that time.
        - The OIG review of inactive cases showed the following:
            - Levels of service provided in the inactive case records were consistent with the description above.
            - 65% had no service plan (none is required for this service category by DMHMRSAS licensure); 30% had minimal service plans.
            - Persons in the service category received a total of 17 face-to-face visits in the three months prior to the OIG visit, an average of .26 contacts per person (converts to an average of just over one contact per year).
            - Records documented 38 case management activities (e.g., coordination with other programs), an average of .58 documented activities per person during the quarter (converts to just over two activities per year).
            - 50 of the families of the persons in this status (65%) received some contact from the case manager during the preceding quarter.
- 14 CSBs (35%) feature heterogeneous caseloads, mixing persons with different levels of needs, without tiered or stratified service ratios.
- 20 CSBs (50%) have established caseload limits or caps for their case managers. 20 (50%) have not. The stated caps or limits range from 25 to 40 cases, but most are targets, rather than hard caps or limits.

- All CSBs were asked to estimate the average wait from first request for case management services to first meeting with the case manager. The average is 25 days, ranging from a low of 7 days to a high of 120 days. This period is taken up with collection of needed information, determination of eligibility, and scheduling. Many case managers report that the activities required during this period can constitute a major time demand. Some CSBs assign case manager assistants to help process these activities and relieve the burden on active case managers.
- 36 CSBs assign persons served in Virginia's mental retardation training centers to a case manager (often to a supervisor's caseload). Four CSBs (Fairfax – Falls Church, Highlands, Northwestern, and Rockbridge Area) do not make any assignment of persons in training centers to case managers. Supervisors at these CSBs respond if contacted by the training centers about matters.
- 35 CSBs assign persons at training centers to an inactive or monitoring status. Typically in this status the CSB expects the case manager to make at least an annual visit to the facility and to handle correspondence with training center staff. These visits usually include a number of residents on each trip and do not typically involve scheduling around individuals' annual meetings. Activity may increase significantly if the person achieves "ready for discharge" status.
- 5 CSBs assign training center residents to an active status (Central Virginia, Hampton-Newport News, Loudoun, Rappahannock Area, and Region Ten). It should be noted these CSBs provide this level of service to persons in the training centers even though it is not possible for the CSB to collect Medicaid fee revenue for persons served in state facilities, except within 30 days of their discharge.
- Most supervisors said they would increase staff activity with residents in the training centers and their families if they had additional staffing, which would enable lower caseloads.
- 8 CSBs (20%) have developed waiting list protocols that restrict access to case management services when prescribed staff-to-consumer ratios are reached. In most cases this is done to prevent dilution of the service. Of the eight CSBs that use formal waiting lists, 315 persons are identified as waiting to enroll in case management services, with an average wait for access to case management service among these CSBs of 56 days.

Placement of case management service in the organizational structure

- In all CSBs except two (Region Ten and Colonial) the case management services team reports to the same person in the organizational structure who is also responsible for the delivery of mental retardation residential and day support services, if the CSB provides these services.

Attachment C provides information about structures and protocols by individual CSB.

Additional descriptive information about case management services can be found in Section IV of the report where findings and recommendations are described.

Section IV

Quality of Care Findings and Recommendations

The findings and recommendations that follow have been grouped according to the five Quality Statements for adult mental retardation case management services.

A. Person-Centered Services

The hallmark indicator of quality in case management services is the degree to which these services are designed, selected, and directed by the person receiving services.

Quality of Care Finding A.1: While case managers state that the persons they serve have a significant role in developing their own service plans, case management records only partially reflect this goal.

The OIG asked case managers the following questions to gain an understanding of the roles of the persons they serve in developing the individual service plan. The same questions were used by OIG staff to evaluate persons' input to their own plans and goals as shown in the individual case records.

Which of these choices best describe how most persons' plans and goals (CSP) are developed?	Case Manager Responses	OIG Findings from CM Records
Case manager develops comprehensive individual services plan (CSP) for the person and explains it to the person and family or AR.	3 %	28%
Case manager involves persons and their families in developing their CSP, inviting the person to share in creating goals.	76%	64%
Persons served and their families substantially lead the development of their own needs assessment and CSP, in their own words, with case manager support.	21%	8%

- Almost all case managers (97%) reported that the persons they serve are significantly involved in developing their plans, either sharing or leading the development of their own goals.
- OIG review of records did not substantiate the case managers' views about the degree of person-centered planning, as fewer records (72%) showed persons sharing or leading development of their plans than case managers estimated (97%). OIG inspectors' evaluation of the goals, the process of goal development, and the degree of involvement of the persons served showed that 28% of the records reviewed had little documented evidence of real involvement of people in development of their plan.

- CSBs that had the best results in documentation of person-centered planning had records with dedicated sections or questions in the record format which required the documentation of the person's own statement of goals, dreams, preferences, etc.
- Case managers felt strongly (82%) that their CSB "allows persons enough choice and self-determination in choosing their services;" 89% said that the service plans of the persons they serve are "driven by personal choices and preferences." 96% said that the service plans are reflective of input received from persons served, their families, and relevant providers at planning meetings.
- While only 21% of case managers state that new clients of case management can choose their own case managers, 63% of case managers and almost all supervisors noted that persons can request a different case manager if they wish after services have begun.
- 67% of case managers said that persons can request to switch their case management services to a nearby CSB when they move to a residence outside their home CSB area.
- When asked what CSBs do to encourage choice by persons receiving case management services, 63% of supervisors referred to the CSB's endorsement of person-centered planning principles and provision of training and supervision in these areas. 26% mentioned allowing persons to change case managers.
- 59% of case managers said that their agency had provided training on person-centered planning and self determination within the last year.
- A survey of 92 family members and authorized representatives of persons receiving case management services from the sample CSBs reported they were satisfied with the degree of input that both their family member (85%) and they (82%) had in the development of service plans.
- 65% of the 26 private residential providers interviewed reported that they were "mostly" satisfied with the level of participation and communication their staff had in the development of their residents' overall services plans. 31% said they were "somewhat" satisfied. (One respondent did not know).

Quality of Care Recommendation A.1: It is recommended that DMHMRSAS, with the involvement of DMAS, CSBs, persons served and their families, develop a model case management service planning system and format that is person-centered and meets all regulatory requirements. (Note: It is the understanding of the OIG that this work is currently being addressed by the DMHMRSAS Person Centered Practices Leadership Team, a widely representative group of public and private residential and day support providers from both the community and state facilities, including advocates, family members, and self-advocates. This effort is in response to an identical recommendation from the earlier OIG Review of Community Services Board Mental Health Case Management (OIG Report #128-06) and similar recommendations from OIG Report #126-05, Review of Community Residential Services for Adults with Mental Retardation and OIG Report #127-05, Systemic Review of State-Operated Training Centers.

DMHMRSAS Response: *The DMHMRSAS, in collaboration with the VACSB, private providers, and other agencies and advocates have developed, though The Person-Centered Practices Leadership Team a draft of a new process and tools to help case managers support individuals with intellectual disabilities in planning for living lives of their choosing. It will be field tested during the winter by interested CSBs, case managers, individuals, regulators*

and other stakeholders for ease of use, utility and effectiveness, thoroughness and ability to capture relevant information. Spring, 2008, is targeted for the widespread use of the new process. This process, once field tested and refined, will serve as a model for the Commonwealth's case management system, with recommended formats and processes that meet all regulatory standards and lead to positive, person-centered outcomes for individuals receiving supports in Virginia.

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Quality of Care Finding A.2: Neither case managers nor supervisors expressed strong dissatisfaction or disapproval of the term case management.

- When asked if case management is an accurate name for the service, just over half (55%) of the case managers who answered this question said it is not; 45% said it is accurate.
- When asked what would be a better name, 50% of case managers made no alternate name suggestions.
- 50% of case managers did offer more than 60 alternative names. Only "service coordinator" gathered significant support (mentioned by 30% of those offering alternative suggestions). Many suggestions used the terms care or service instead of case. The word management was often replaced by coordinator, specialist, or advocate.
- 30% of supervisors expressed some discomfort or uncertainty with the name case management. Few offered suggestions for changes, with care coordinator or service coordinator being mentioned most often. Most did not feel it was an issue for persons receiving services and felt that the name was too well established with everyone to change.
- Only two CSBs actually use different names. Highlands uses care coordination, and Chesapeake uses service coordination.
- The literature of person-centered planning and "person-first" language is beginning to describe "case management" as an undesirable term.
- OIG inspectors noted generally good use of "person-first" language in records and discussions with case managers and supervisors.

No Recommendation

B. Coordination of Services

Case management coordinates needed supports in a comprehensive manner, affording the person and his or her family the greatest possible choice among providers and services.

Quality of Care Finding B.1: Mental retardation case management activities appropriately focus on linkage and coordination of services.

OIG inspection of 275 records of active case management at the sample CSBs found that MR case managers emphasize coordination of services with other providers. A total of 1,358 collateral contact activities were documented in progress notes for 275 active case management charts during this period. This is an average of 7.8 collateral contact activities per quarter per person served, or just over 30 such contacts per year.

In addition to the services coordination activities, a high percentage (48%) of service evaluation activities took place during the quarter. Most of these contacts consisted of case manager's inquiries and notations of the person or his/her family's satisfaction with services at various programs, a Medicaid requirement.

- The types of service coordination activities documented, shown as percentages of the total numbers of these services provided (1,358 notations), were as follows:

Case Management Service	Percent Provided in Quarter Reviewed
Linkage and coordination of services (other than day support and residential, e.g., SSA, MH, transport.)	67%
Contact with day support services provider	64%
Contact with residential services provider	52%
Evaluation of services received by the person	48%
Arrangement of Medical Services	44%
Supportive counseling	10%
Advocacy for the person	10%
Crisis Support Services	2%

No recommendation

Quality of Care Finding B.2: Persons receiving mental retardation case management services face severe shortages of core services needed for successful integration and independence in the community – residential services options, day support and employment options, reliable transportation, timely access to mental health services (therapy, psychiatric medicine), and crisis intervention options. Choice is limited by scarcity of varied service options.

- 62% of case managers said there is not "a sufficient array of residential and day support services in my area to provide appropriate choice…for the persons I serve."
- 69% of case managers said their clients do not have "access to safe, affordable housing of their choice." 41% said they had "serious concerns" about the residences in which some of the persons they serve live.
- 51 % of case managers said the persons they serve do not have access to needed job training, job supports, or jobs.
- While a majority of case managers (68%) reported that the persons they serve enjoy a variety of social opportunities and relationships in the community (other than with their own families or persons paid to be with them), nearly a third (32%) disagreed and indicated that persons do not have these opportunities for community integration and participation.
- When staff were asked what "one or two changes" they would like to see to make case management better, 32% of the total responses from supervisors and 33% of case

managers' comments concerned the need for increased service options for the persons served.

Quality of Care Recommendation B.2: It is recommended that DMHMRSAS and DMAS continue to work cooperatively to seek avenues to steadily increase the capacity of core support services in the community – residential services, day support and employment options, reliable transportation, timely access to mental health services and crisis intervention options.

DMHMRSAS Response: *The staff of the Office of Mental Retardation (OMR) of DMHMRSAS continues to meet regularly with the staff of DMAS in collaborating on issues related to the Medicaid Waiver. One recent collaborative effort which also involved other departments, agencies, advocates, and individuals was the study of the MR Service delivery system for the General Assembly. This study makes recommendations on a variety of issues related to improvements in the capacity of core support services to persons with intellectual disabilities, including residential services, day support and employment options, reliable transportation, timely access to mental health services and crisis intervention options. The two Departments will continue to coordinate their efforts in emphasizing the service capacity needs of the Commonwealth through their individual and collective statistical reporting and budget requests.*

Quality of Care Finding B.3: Case managers encounter significant problems in providing or securing the therapy, supportive counseling, and psychiatric services needed by the persons they serve who have dual diagnoses of mental retardation and mental illnesses and/or behavioral challenges.

1. While scientific and program literature has long documented that persons with mental retardation have at least the same and probably higher prevalence of mental illnesses than the general population, diagnostic imprecision, different interpretations of behaviors and uncertainty persist.
2. The general thrust of the literature and professional opinion leaves no doubt that persons with mental retardation experience difficulty having their mental health needs identified and receiving treatment from the mental health service system.
3. Case managers interviewed in the sample identified that an average of 28% of the persons they serve have co-occurring diagnoses of mental illnesses and mental retardation. They also said that an average of 20% of the persons they serve have "significant behavioral challenges that require intervention."
4. 76% of case managers say that the persons they serve do not have access to outpatient therapy services when they want and need it.
5. 80% of case managers say that the persons they serve do not have access to a psychiatrist without undue waiting.
6. The average of 40 CSBs reporting is that persons with mental retardation must wait 33 days for a first appointment with a psychiatrist. This ranges from a low of six days to a high of 252 days. Persons receiving case management services at some CSBs do not have access to psychiatry services at their CSB.

7. Only 39% of case managers think their CSBs are well structured to integrate mental health and mental retardation services; 61% think that there are barriers and challenges to getting mental health services for the persons they serve.
8. While 72% of case managers say they are well prepared by training and experience to meet the co-occurring mental health disorders of the persons they serve, few provide this service. 10% of contacts were characterized by OIG inspectors as "supportive counseling." Analysis of case manager qualifications (see Attachment G) does not suggest that case managers are qualified to provide mental health services. Only 2% are licensed, and only 16% have masters degrees.
9. Over half (56%) of MR case managers said that the roles of state MH hospitals and MR training centers are not clear regarding response to crises that involve persons with mental retardation.
10. These findings, that persons with mental retardation who experience emotional or behavioral crises are often not able to access crisis intervention services, was documented previously by the OIG in the Review of Virginia Community Services Board Emergency Services Programs (OIG Report #123-05).

Quality of Care Recommendation B.3.a: It is recommended that each CSB review current programming in mental health and mental retardation services to identify gaps in programming to address the needs of individuals with mental retardation who have co-occurring mental illness and/or challenging behaviors. It is further recommended that each CSB develop and implement a plan to address the identified gaps.

DMHMRSAS Response: *The staff of OMR and the leadership of the Community Services Division of the DMHMRSAS will collaborate with the MR Leadership of the VACSB and the Mental Retardation Council, the Executive Directors Forum of the VACSB, and the Data Management Committee of the VACSB to develop a plan by which each CSB can conduct a review of current programming in mental health and mental retardation services to identify gaps in programming to address the needs of individuals with mental retardation who have co-occurring mental illness and/or challenging behaviors. The plan to identify the gaps will be developed by January 30, 2008 for implementation by each CSB during the remainder of the fiscal year. Each CSB will be asked to have a plan in place to address the identified gaps by December 31, 2008.*

Quality of Care Recommendation B.3.b: It is recommended that DMHMRSAS compile a statewide description of programming needs identified in the local plans that cannot be met with existing resources and seek funding to help address these needs.

DMHMRSAS Response: *The OMR staff will utilize the information concerning gaps in services gathered in response to Recommendation B.3.a to develop proposals for funding during the annual budget cycles.*

Quality of Care Recommendation B.3.c: It is recommended that DMHMRSAS establish a statewide policy that clarifies the safety net role of the training centers in providing emergency services to consumers with mental retardation who demonstrate severe behavior management problems or may have a severe mental illness. This policy should state clearly

what conditions are appropriate for emergency admission, which are not, and when it is appropriate for an individual with either of these conditions to be admitted to a state mental health hospital.

DMHMRSAS Response: *The DMHMRSAS provided Regional Utilization Management Guidelines to each of the seven Partnership Regions in January of 2007 that sought to gain best practice models for use of the State Training Centers and State Psychiatric Facilities, including how regions were addressing the needs of individuals with dual diagnosis. Subsequent to the guidance memorandum, Department leadership has met with five of the seven regions to review current practice and the two remaining regions will be visited by the end of October. The Department intends to have a statewide meeting of the regional leadership to review best practice models in all areas and a joint CSB/BHA and Department team will build upon the knowledge gained to develop and disseminate Regional Utilization Management Standards. The standards will address the issues identified in this recommendation.*

Quality of Care Finding B.4: A majority of families and authorized representatives of persons served by CSB case management report that they and their family members experience adequate communication, involvement, and choice in development of their family members' service plans and selection of community supports.

Family members' views

- 64% of families said that they were afforded sufficient choice of providers and services. 17% were not satisfied with their choices and felt they had to take the few options or vacancies that were available. 18% were not sure or did not know.
- Many commented on the need for additional services or their long wait to access a waiver slot, saying that their choice was limited to the vacancy that was available.

CSB supervisors' views

- 57 supervisors at the 28 sample CSBs were asked what their CSBs do to guarantee that persons and their families served by case management have full and free choice among providers.
    - 37% of the responses specified providing a list of area or statewide providers.
    - 20% of the comments stressed the supervisors' strong commitment to this principle, saying that they assure even-handedness in selection of service options through supervision, and setting a clear policy and expectation. 18% of the comments mentioned arranging tours, with two saying that "every person must visit every provider" when choosing services. 6% of the comments mentioned "provider fairs" or active outreach to providers.
    - 7 % of the comments said bias of choice toward the CSB is not a problem because the CSB does not directly operate similar services.
    - Two CSBs (Region Ten and Colonial) said they organize MR case management services under an organizational division that is separate from the division that provides the majority of direct mental retardation

services, so as to better assure independence of service brokerage activities.

CSB case managers' views

- Case managers were asked various questions about provision of choice.
    - 62% of case managers said they do not feel pressure to "guide consumer and family choices to the residential or day support services operated by their own CSB, rather than other providers." 18% answered that they do feel some pressure to guide selections to CSB-operated services. (The remainder are from CSBs that do not offer these services.)
    - 62% of case managers said there is not a sufficient array of services available to allow appropriate choice for most of the persons they serve, that individuals must take the vacancy or only option that is available.
    - While some limits of choice exist *among* service options, 87% of case managers say preferences and choices are honored *within* the case management, day support, and residential programs that persons receive.

Private residential providers' views

- 65% of providers answered "yes/mostly" to a question asking whether their staff had adequate communication and involvement with the case manager in the involvement of residents' plans and services. 31% answered "somewhat," 4% (one person) did not know.
- 50% of providers said that choice is supported and enabled by case managers, and 50% said that case managers do not afford adequate choice to persons and their families among residential service providers. The 50% of providers who said that choice is limited by case managers cited one or more of the following concerns:
    - Case management, when attached to a CSB that also provides services is thought to create an inherent conflict of interests.
    - Persons should have the right to choose case management providers, rather than have to rely on only the CSB.
    - There is reason to believe that case managers from CSBs that offer residential services seek to fill their own vacancies first or otherwise favor their CSB's services.
    - Some case managers favor some providers over others, usually based on past experience, sometimes out of habit.
    - Some CSBs do not maintain full and up-to-date lists of available providers and that case managers are not well informed about all providers' capabilities.

No recommendation

Quality of Care Finding B.5: When a person's ability to choose is limited, and professional and legal judgment suggests a form of substitute consent is needed, it is difficult to find qualified persons to serve as authorized representatives and guardians.

- A majority of case managers (61%) think that many of the persons they serve are not adequately capable to make decisions about their needs and need a guardian or authorized representative.
- 82% of case managers said that finding persons to serve as authorized representatives or guardians is a "big problem."
- When persons do have families or authorized representatives to help them make decisions, 91% of case managers think that they make good decisions for the persons the case managers serve.
- The OIG is aware that DMHMRSAS is working with the Virginia Department for the Aging (VDA), with funding provided for this biennium from the General Assembly, to expand the number and capacity of public guardianship programs statewide.

Quality of Care Recommendation B.5: It is recommended that DMHMRSAS continue to monitor needs as this program progresses.

DMHMRSAS Response: *Recent access to Virginia's public guardianship program has significantly improved the ability of individuals needing substitute decision makers to obtain them. As this program continues to evolve, the OMR will monitor its progress and will continue to identify gaps in this area.*

Quality of Care Finding B.6: Persons who are served by mental retardation case management are generally unable to gain access to their case managers after normal business hours and on weekends, when they must contact the CSB's emergency services program.

- 72% of case managers reported that the persons they serve are not able to reach them after hours; 28% said this access is available (in most of these cases staff have given persons their numbers and allow limited calls to their cells or homes).
- None of the supervisors or service directors reported that case managers are required to make themselves available after hours.
- The standard practice is for calls to go to CSB emergency services programs (ESP) after normal business hours. Most CSBs have an understanding or a formal process for the ESP to contact a mental retardation services supervisor in crises. Some CSB emergency services programs have protocols to contact the case manager at home directly under certain circumstances. One CSB described a system of MR on-call staffing to take initial calls from persons served by the MR system, rather than using the ESP.
- Most case managers alert the ESP that a person may be likely to experience a crisis during a specified period. It is possible that some crises could be avoided or reduced in intensity if persons are were able to reach someone they know in times of crises.
- As a part of this review, the OIG made phone calls to 250 family members and authorized representatives using the most recent available phone numbers from the sample of cases that was selected for review. In attempting to make these calls, the OIG inspectors discovered that 20% of the phone numbers documented in the charts had been disconnected or were not in service. A total of 92 family members or guardians were interviewed.

- While case managers may have their own systems for maintaining an accurate record of these phone numbers, the fact that so many numbers are out of date in the charts may well result in other staff having difficulty reaching these individuals in emergency situations.

Quality of Care Recommendation B.6.a: It is recommended that CSB's investigate the use of systems by which persons can reach their own case managers or a knowledgeable backup in times of crisis so that they might speak to someone they know and trust rather than routinely having to deal solely with the emergency services system after regular business hours.

DMHMRSAS Response: *DMHMRSAS supports this recommendation for the CSBs. DMHMRSAS Office of MR will collaborate with the CSB MR Directors and case managers in developing standing regional case managers in developing a policy/guidance document regarding individuals' access to a known CSB employee after regular business hours for discussion and development through the VACSB leadership. DMHMRSAS will begin this task immediately and target July, 2008 for an initial draft report. A final report on the outcome of this work will be delivered to the Inspector General's Office by 12/31/08.*

Quality of Care Recommendation B.6.b: It is recommended that CSBs assure that all parties that may have reason to contact family members and/or authorized representatives in emergency situations have access to accurate phone numbers.

DMHMRSAS Response: *DMHMRSAS supports this recommendation for the CSBs. The Person-Centered Principles Leadership Team, as part of its development of a new process and tools to aid individuals with intellectual disabilities in planning their desired lives (see Response to Recommendation A.1), is in the final stages of refining a compilation of all essential information/data elements needed by CSBs, private providers, DMHMRSAS and DMAS for helping individuals with intellectual disabilities to access and utilize services and supports, assure health and safety, and comply with all relevant regulations. The essential information component includes information that changes infrequently, such as emergency contacts, medical/clinical professionals' contact information, financial resources, diagnostic and eligibility information, medication, social history, plan of care summary, etc., but are easy to update and share with providers when changes occur. At present, the draft document is a four-page paper form, but it is hoped that, as part of the Systems Transformation Grant, this information will be a component of the individual's Electronic Health Record. During the winter, DMHMRSAS will continue to work with the PCP Leadership Team to finalize and field test this form, with the target time frame for widespread implementation being Spring, 2008. DMHMRSAS will report to the Inspector General's Office on the outcome by 12/31/08.*

Quality of Care Finding B.7: Efforts by CSBs to identify needs and to help people transition from public school special education programs into community services for adults vary greatly among CSBs.

- OIG interviews with supervisors show that 40% of CSBs assign mental retardation case managers to work with children and young adults and their families, especially as they approach completion of their school experience. Case managers in the sample said that an average of 10% of the persons they serve were below age 18. This approach offers ongoing communication and preparation for transition to adult services when the child leaves school.
- Many CSBs use active and creative methods to contact families and engage them in documenting needs and preparing to use or deal with the scarcity of adult services. Some CSBs involve older students in community day support programs as orientation or as full components of their school experience. 33% of supervisors reported active efforts to make contact and facilitate transition from school programs to CSB services for adults. Working with the schools to contact parents, serving on transition committees, and attending orientation meetings are examples of this level of activity.
- 13% of supervisors described a more passive approach of waiting for schools or parents to call about graduating pupils, often just before or even after they graduate.
- For the CSBs that may deal with multiple school divisions, sometimes as many as 6 to 10, spread over a large geographic area, active outreach is a challenge.

No Recommendation

C. Consumer/Case Manager Connection

Case managers and the persons they serve share a constructive interpersonal helping connection that fosters trust, cooperation, and support for each person's pathway to greater independence and self determination.

Quality of Care Finding C.1: Case managers are committed to the persons they serve and their commitment and respect is noted and appreciated by family members.

- Families expressed high levels of satisfaction with CSB case manager services:
  - 85% said they were satisfied with the level of support and services the case manager provides to their family member.
  - 82% said they were satisfied with the level of support, information, and services the case manager provides to them, as family members.
  - 97% of family members said they thought the case manager always treats their family member with dignity and respect.
  - When asked what one thing they would like to see changed to improve case management services, 64% said nothing needs to be changed. 15% offered suggestions for improvement that focused on case managers, most wishing that they would see them more or have more communication. The remainder (21%) made suggestions about the overall service system, rather than case management, most saying more service options are needed, more funding, etc.

- Private residential services providers offered a mixed evaluation of the case management services that the person they serve receive.
    - 46% said they were mostly satisfied and 42% said that they were somewhat satisfied with the supports and services that case managers provide to their residents.
    - 12% said they were not at all satisfied. The majority of the negative criticisms focused on a perceived need for case managers to increase their levels of direct services (such things as arranging appointments, advocating for services, shopping trips, visits to the homes, etc.). These providers said that these duties most often fall to them as providers because they know the persons better and cannot wait for the case managers to find time to do these things.
- Case managers find meaning and satisfaction in helping the people they serve.
    - In response to a question asking what case managers *most like* about their jobs, there were 256 responses from case managers. 81% of the comments expressed positive feelings about the persons they served and the enjoyment case managers feel seeing the persons make progress.
    - In another question, which asked case managers to say what they *like least*, the second-highest dislike (25% of the 254 total comments) was that their clients did not have all the services they need or that they did not have enough time to help them as much as they wished**.** As shown below, case managers said they did not have enough time to help their clients as much as they wished due to what is the overwhelming negative about case management: 74% said too much paperwork kept them from helping their clients.
    - 74% of case managers said their teams have good morale.

No recommendation

Quality of Care Finding C.2: While a majority of case managers have tenure on the job that enables continuity in the relationships with those they serve, a significant minority of staff (26%) have been on the job 12 months or less which results in disruption to the supportive relationship. Turnover varies significantly among the 40 CSBs.

- The average (mean) tenure of case managers of all 40 CSBs is 5.9 years, the median (midpoint) is 3.3 years, the mode (most frequently occurring value) is 1 year.
- Family members who were interviewed did not identify rapid or frequent turnover of case managers as a major problem for them or the persons receiving case management. 31% said turnover was "somewhat" or "yes, mostly" a problem. 72% said turnover was not a problem. Many reported that, even though new case managers may be introduced, they usually seemed well prepared and quickly were able to relate to the person and his or her family.
- 66% of private residential services providers said that turnover of case managers was mostly or somewhat a problem, 35% said turnover was not at all a problem.
- Supervisors at the CSBs have varying opinions regarding the extent to which staff turnover is a problem. Of 57 service directors and supervisors interviewed, 63% said that "too much turnover" is not a problem at their CSBs. 33% said turnover is a problem for them.

- The distribution of tenure validates the observations of many supervisors that there is a core group of long term case managers who have stayed at their jobs for a very long time, with whom there is very little turnover: 22% have tenure as case managers for ten years or more. This is balanced by a larger group - 26% - of persons who have been in their jobs for *less than 12 months*. Supervisors commented that the greatest turnover occurs with newer staff, who are often younger people who experience life changes (going back to school, moving to a new community).
- Supervisors said that the major reasons for people staying in their jobs have to do with providing a supportive work environment, which includes scheduling flexibility and supportive team approaches. Reasons for shorter tenure were led by concerns about salary and advancement opportunities, workload (primarily paperwork), and the natural life changes of younger persons (return to school, moves, families, etc.)

No recommendation

D. Case Management Activity and Outreach

Case management is a vigorous, active service, with frequent face-to-face and collateral contacts provided at a level sufficient to assure positive outcomes, guided by the preferences of the person receiving services.

Quality of Care Finding D.1: The frequency of face-to-face contact by CSB mental retardation case managers with the persons they serve averages about twice a quarter (2.2) or just under nine per year (8.8) which is more than the minimum required by Medicaid.

- The OIG reviewed 275 case management records in order to document the number of face-to-face interviews by case managers with persons served during the previous 90 days and to determine the location of these visits. OIG inspectors counted contacts included in individual progress notes, monthly summaries, and service coding in a sample of records (normally eight records per board, with larger samples drawn from very large service populations at some CSBs).
    - An average of 2.2 documented face-to-face contacts between case managers and the persons they served occurred in the 275 records during the quarter, exceeding the Medicaid minimum requirement of one face-to-face contact per quarter.
    - Average face-to-face contacts in records by CSB during the quarter ranged from a low of 1.1 to a high of 4.4.

  Average face-to-face contacts for persons served at each CSB in the sample are shown in appendix E.

- Families and authorized representatives reported the following frequency of face to face meetings with case managers:
    - No meetings or less than once a year 12%
    - Quarterly or a few times a year 52%
    - Monthly 34%
    - Weekly 4%

    - Most often, face to face meetings with family members took place at planning meetings with other agency representatives present.
- Provider agencies were asked how often the majority of case manager face-to-face visits occurred.
    - 77% said most case managers see their clients face-to-face on a quarterly basis.
    - 15% said these visits take place on a monthly basis.
    - 8% said case managers see their clients once a year or less.
    - Many residential providers said that they might not be aware of all case manager visits with the persons they serve, that these estimates reflected times when their staff observed case manager visits.
    - When asked what things they would like to see improved about mental retardation case management, the leading response of providers was that they would like to see higher levels of direct work by case managers with the persons they serve. Many residential providers noted that much of the "casework" that they believe case managers should do falls to residential staff.
- As noted earlier, 81% of case managers said that direct work with the persons they serve and seeing them make progress are the things they like most about their jobs.
- Case managers expressed great frustration with their inability to spend more time with the persons they serve. When asked what suffers or does not get as much attention as needed when they face pressures and stress of their workload, 59% said direct service work with their clients is what gets short changed.
- Case managers identified their caseload size and, especially, paperwork requirements as the factors that prevent them from spending more time with their clients.

Quality of Care Recommendation D.1.a: It is recommended that CSBs assess what changes in administrative requirements, case load size and staffing levels are necessary to increase the level of face-to-face activity case managers are able to have with the persons they serve and to implement these changes.

DMHMRSAS Response: *DMHMRSAS supports this recommendation for the CSBs. DMHMRSAS Office of MR is collaborating with the CSB MR Directors in developing standing regional case management committees or council groups. One of the tasks that DMHMRSAS will request that these committees address, with the assistance of DMHMRSAS staff, is the identification of needed changes in administrative requirements, case load size and staffing levels in order to facilitate greater face-to-face access of individuals to their case managers, as this desired outcome was expressed by both case managers and service providers. DMHMRSAS will begin this task immediately and target July 2008 for an initial draft report. A final report on the outcome of this work will be delivered to the Inspector General's Office by 12/31/08.*

Quality of Care Finding D.2: Most case management visits to persons served take place out in the community.

The table in Attachment E provides information on location of visit for each CSB in the sample.

- The OIG review of the sample CSBs' case records for the 90-day period immediately prior to the site visits showed the following pattern regarding the location of visits between case managers and the persons they serve:
    - Day support program – 40%
    - Out in the community with the person shopping, at doctor's offices, etc. – 13%
    - In the residence where the person lives – 32%
    - Case manager's office or CSB office – 14%
- Family members confirmed these patterns, saying that 39% of their meetings with the case manager take place in the residence in which their family member lives; 37% report meetings in the day support site; and 16% report meetings in the case managers' offices.
- All the 57 supervisors interviewed stated that case management should include visits to a variety of all the sites that are important to the person's life which is in accordance with Medicaid requirements.
- 16% of supervisors said they require at least a quarterly visit to the home. The remainder require an annual visit, or have no specific expectation, but expect visits "as needed."
- 92% of case managers said they feel safe visiting and working with person at their residences and out in the community.
- 62% of providers said that the majority of face-to-face visits take place at the day support programs; 31% said the majority of visits occur in the persons' residences; and 4% identified the case managers' offices as the most frequent spot for meetings.
- Private providers indicate that more case manager contacts should occur in the residence.

No Recommendation

Quality of Care Finding D.3: While little information is available regarding national standards to which Virginia caseloads can be compared, many family members, CSB case managers and supervisors, and private providers indicate that increased face to face contact by case managers with those they serve is needed and that caseload size serves as a barrier to adequate contact.

- The average caseload size in Virginia's 40 CSBs is 35.6.
- The OIG was not able to identify studies that have resulted in recommended caseload size for case managers who serve those with mental retardation. Officials at the National Association of State Developmental Disabilities Programs (NASDD) recommend a caseload size of 30-35, though they point out that variables such as differences in service expectations, documentation requirements, and levels or tiers of persons' services needs must be considered in establishing a standard.
- 17 CSBs (43%) have caseload sizes that are over 35, the upper end of the NASDD recommendation.
- Caseloads vary from a low of 19 (Dickenson County CSB, which has only one case manager) to a high of 46.9 (District 19 CSB). Caseloads were calculated from data supplied by all 40 CSBs for May, 2007. In many cases, discussions were necessary with CSB staff to attempt to resolve considerable differences in how CSBs reported such variables as staff vacancies, exclusion of children from this review, calculation of FTEs, and, especially, the status and level of services received by persons in such categories as inactive, monitoring, follow-along, etc.

- Supervisors at the sample boards were asked to estimate **"**the target caseload size for a full time mental retardation case manager in Virginia." The average of answers given by the 57 supervisors interviewed was 27.1, with a range from 15 to 42. Generally these answers were for a mixed caseload of around 20-25 Medicaid waiver clients and 5-10 "inactive" persons.
    - 32 of the 40 CSBs (80%) have average caseloads for mental retardation case managers that exceed the estimated target caseload size provided by of CSB case management supervisors: 27.1.
    - High levels of agreement exist among CSB supervisors regarding the need for lower caseload limits to provide needed supports to individuals and their families and to handle the administrative and documentation requirements of Medicaid waiver and Targeted Case Management.
    - Practices in defining "inactive" cases vary greatly among CSBs.
- Case managers were asked to describe their own caseloads. Their estimates of their current caseloads were very similar to the averages provided by the CSBs. The mean, or average, of their responses (N=262 case managers) is shown in the table below:

Total Active Cases	Total Inactive Cases	Total Overall Caseload
30.3	5.3	35.0

- Case managers feel strongly (74%) that their caseloads are too large for them to do all they think they should for the persons they serve.

The following chart shows mental retardation case management caseload size for the 40 CSBs as submitted to the OIG:

AVERAGE CASE MANAGER CASELOAD	
	Caseloads As Reported by CSBs
Alexandria	26.7
Alleghany Highlands	22.3
Arlington	28.0
Blue Ridge	41.9
Central Virginia	44.5
Chesapeake	39.8
Chesterfield	37.6
Colonial	33.9
Crossroads	36.4
Cumberland Mountain	38.8
Danville-Pittsylvania	36.1
Dickenson	19.0
District 19	46.9
Eastern Shore	31.3
Fairfax-Falls Church	43.8
Goochland-Powhatan	27.7
Hampton-Newport News	33.9
Hanover County	34.2
Harrisonburg-Rockingham	37.9
Henrico Area	40.0
Highlands	32.4
Loudoun	29.8
Middle Peninsula-NN	28.1
Mt. Rogers	40.2
New River Valley	21.9
Norfolk	31.8
Northwestern	23.5
Piedmont	34.7
Planning District One	31.5
Portsmouth	29.1
Prince William	36.0
Rappahannock Area	44.2
Rappahannock-Rapidan	46.2
Region Ten	31.2
Richmond	35.6
Rockbridge Area	23.2
Southside	32.4
Valley	33.6
Virginia Beach	29.5
Western Tidewater	46.0
Statewide Average	**35.6***

* Derived from total FTEs assigned and total persons served, as reported by all CSBs, not an average of these averages.

Average caseloads for each CSB sorted by caseload size can be found in Attachment F.

- The leading suggestions from case managers and supervisors is that caseload sizes should be reduced by adding additional case managers, or that the time available for case managers to meet their responsibilities be increased by reducing paperwork requirements.
- CSBs were asked how many more case managers would be needed to provide adequate levels of service to all the persons in need of case management and to reduce waiting lists. These are their estimates of additional staffing to meet needs, not just to reduce caseloads (new clients would be added, services increased to others). Responses are provided below:

Number 0f Additional Case Managers CSBs Estimate Are Needed			
Alexandria	0	Highlands	0
Alleghany Highlands	1	Loudoun	3.5
Arlington	3	Middle Peninsula-Northern Neck	2
Blue Ridge	6	Mt. Rogers	3
Central Virginia	5.5	New River Valley	0
Chesapeake	3.5	Norfolk	3.5
Chesterfield	7	Northwestern	0
Colonial	2	Piedmont	2
Crossroads	3	Planning District One	1.5
Cumberland Mountain	3	Portsmouth	0
Danville-Pittsylvania	4	Prince William	4
Dickenson County	0	Rappahannock Area	4
District 19	5	Rappahannock-Rapidan	3
Eastern Shore	0	Region Ten	3
Fairfax-Falls Church	19	Richmond	6
Goochland-Powhatan	0	Rockbridge	0
Hampton-Newport News	0	Southside	2
Hanover County	3	Valley	3
Harrisonburg-Rockingham	1	Virginia Beach	2
Henrico Area	7	Western Tidewater	7
STATEWIDE TOTAL - 122.5 Positions			

Quality of Care Recommendation D.3.a: It is recommended that DMHMRSAS study the advisability of establishing a caseload standard for CSB case managers who work with individuals with mental retardation and establish such a standard if it is determined advisable.

DMHMRSAS Response: *DMHMRSAS Office of MR is collaborating with the CSB MR Directors in developing standing regional case management committees or council groups. DMHMRSAS, in conjunction with these committees, will examine the advisability of establishing a caseload standard for CSB case managers working with individuals with mental retardation, giving consideration to the many factors (such as geography, urban/rural nature of the area, size of the catchment area, number of individuals on Waiver, etc.) that affect the ability of case managers to be effective across the diverse areas of the state. DMHMRSAS will begin this task immediately and target July 2008 for an initial draft report. A final report on the outcome of this work will be delivered to the Inspector General's Office by 12/31/08, at which time the standard will either be set or a determination made as to the inadvisability of such a standard and the reasons for such a determination.*

Quality of Care Recommendation D.3.b: If it is determined that a caseload standard is advisable and if caseload levels at CSBs significantly exceed this standard, it is recommended that DMHMRSAS seek additional resources to lower the average caseload.

DMHMRSAS Response: *In the event that DMHMRSAS, in conjunction with the case management committees, determines that a particular caseload standard is advisable and discovers that caseloads in Virginia tend to be significantly more than this standard, DMHMRSAS will seek additional resources to enable CSBs to lower the average caseload. DMHMRSAS will report back to the Inspector General's Office on the need for this action by 12/31/08.*

Quality of Care Finding D.4: Case management service recipients have the same access to and receive the same level of case management service regardless of eligibility for Medicaid as a payment source. However, Medicaid recipients do have greater access to other services such as mental retardation support services, transportation, affordable medications and outpatient services.

- A small minority of the persons who receive active mental retardation case management from CSBs do not receive Medicaid and are not eligible for Medicaid-funded targeted case management. Differences in how CSBs answered these questions and variations in local funding patterns make these estimates less than certain, but the figures supplied suggest that 12% of persons receiving case management have no reimbursement for case management services.
- All CSB case management supervisors and most (62%) of the case managers who were interviewed by OIG inspectors reported no differences between Medicaid-funded Targeted Case Management (TCM) and case management services received by persons not funded by Medicaid. 38% percent of case managers who said there *are* differences pointed to the paperwork requirements of Medicaid-funded TCM (especially in waiver cases) and the funded access to other services that persons with Medicaid have that persons without Medicaid do not. Most insisted that the case management service *as experienced by the individual* is identical. A few said that some persons without Medicaid might be less likely to receive the minimum of a monthly contact that a TCM client must receive as required by Medicaid.
- Based on record reviews and interviews with case managers and consumers, OIG inspectors did not detect variation in the level of case management services received by persons with Medicaid funding and those without dedicated funding for this service.
- Non-Medicaid clients have less access to other services that Medicaid covers. This includes services such as basic health care, transportation to service appointments, affordable medications, and outpatient therapy.

Quality of Care recommendation B.2 addresses the need for expanded community service availability

E. Case Manager Preparation and Support

Case managers must have knowledge, skills, and training specific to the wide range of tasks a case manager must provide. Case management is an essential service and its providers must be supported and recognized as core mental retardation professionals.

Quality of Care Finding E.1: Case managers and supervisors have appropriate education levels and experience for their positions.

- CSB executive directors certify case managers' possession of needed knowledge, skills, and abilities according to Medicaid provider requirements. There is no externally mandated degree requirement.
- Case manager's educational and licensure levels vary across the state. 90% of case managers have a bachelor's degree or master's degree, are licensed as an LCSW/LPC, or are nurses. The percentage of various educational and licensure levels across the CSB system is provided below. CSB specific information can be found in Attachment G.

Educational Levels of Case Managers:	Nurses	LCSW/LPC	Master's	Bachelor's	<B.A.
Percentage	1%	1%	16%	72%	10%

- The average tenure for supervisors who oversee case management services is 10.7 years in these positions.

No recommendations

Quality of Care Finding E.2: Case managers receive little training in topics specifically related to case management. Preparation and certification of the skills and abilities of case managers vary among CSBs, and are rarely formally documented.

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- Few, if any, new case managers enter employment at CSBs with formal training or professional preparation to be a case manager, thus training on the job is essential.
- In discussions with case managers and supervisors and in reviewing agency-provided training schedules, OIG staff noted very little training is provided that is specific to the unique role of the case manager. Most training listed was to fulfill generic requirements for all CSB employees (human rights, OSHA, job description, etc.).
- Most CSBs referenced DMAS provider manuals for targeted case management and waiver as the basis for specialized training – these mostly focus on documentation and procedural requirements.
- A majority of CSBs (55%) mentioned that they attempt to send their new case managers to periodic trainings in case management offered by the Office of Mental Retardation of DMHMRSAS and occasionally by DMAS. These sessions mainly deal with the Medicaid requirements for targeted case management and waiver.

- Ten CSBs (25%) listed required training activities that go beyond regulatory requirements and may be considered specific to the particular duties of case managers, covering such things as leading interagency service planning meetings, assessing and coordinating health needs, advocacy, etc.
- Face-to-face interviews with 57 supervisors at the 28 sample CSBs confirmed these findings. When asked what they do to help case managers acquire the special skills they need, 11% noted specific preparation for case managers, 23% mentioned mentoring or shadowing with experienced case managers, but 66% described only general preparation that would differ little from that received by other employees in mental retardation service positions.
- Case managers do not currently have a statewide organization or other convenient way to connect with each other, share training and practice experiences, and otherwise enhance the sense of professionalism in the case management role.
- Case managers were asked a number of questions about whether they consider themselves "well prepared by training and support" (supervision) for some of the issues they face in their roles. Their answers showed a generally high degree of confidence, though this may reflect personal confidence and support from supervisors and peers, rather than formal training:

Case Managers' Opinions of their Preparation for Certain Duties	% Strongly Agree or Agree	%Disagree or Strongly Disagree
Self determination and person-centered planning in last year	59	41
Co-occurring mental health issues	72	28
Cultural diversity	71	29
Assess and coordinate health care needs	82	18
Monitor quality of services	84	16
Advocate for persons served	85	15
Overall training as case manager	73	27

  - Lower confidence – nearly a third of respondents – was reported in three areas (cultural diversity, co-occurring mental illnesses, and overall training in case management).
  - As only one or two training topics listed by all the CSBs specifically addressed monitoring quality and advocacy, the very high levels of confidence shown for these areas suggest sources other than training. During interviews, case managers frequently noted that most of them had come to case management after a period of time in residential and day support services and thereby are familiar with evaluating quality in these programs. These discussions revealed a culture of case management that generally supports and encourages advocacy.
  - Some supervisors and case managers suggested that some form of case manager certification may help to assure and document consistent qualifications and demonstrated competencies for mental retardation case managers across the state.

Quality of Care Recommendation E.2.a: It is recommended that DMHMRSAS initiate a collaborative effort with CSBs and consumers to develop a model training curriculum for mental retardation case managers and that this program be made available to all CSBs.

DMHMRSAS Response: *DMHMRSAS is addressing the need for case management training developed in a collaborative process with case managers and individuals through 1) the training plan to be developed by PCP Leadership Team (see response to Recommendation A.1.), 2) the future availability of the Targeted MR Case Management training in an e-learning format (currently in study) and 3) the regional case management councils described in Recommendation B.6.a. Once this curriculum has been developed, field tested, and refined, DMHMRSAS will implement the statewide curriculum for all case managers by November of 2008.*

Quality of Care Recommendation E.2.b: It is recommended that DMHMRSAS and DMAS, with the involvement of CSBs, study the value of developing certification standards for mental retardation case managers.

DMHMRSAS Response: *The PCP Leadership Team has been considering certification or standards for case managers. This team, along with DMHMRSAS, DMAS, and the VACSB will work together to address the manner in which the Commonwealth can affirm that all case managers meet a statewide minimum acceptable standard of competence. The plan for this minimum standard assurance will be developed by June 30, 2008.*

Quality of Care Finding E.3: Administrative and documentation requirements consume an inordinate amount of staff time (estimated by case managers at 60.3%) and cost, interfering with or reducing service provision rather than supporting it.

- Case managers were asked what percentage of their time each week is taken up by documentation requirements (paperwork). The statewide average based on responses to this question is 60.3%.
- A leading source of case manager dissatisfaction with their jobs is the burden of required paperwork.
- 51% of case managers directly or indirectly listed paperwork burdens as the least favorite aspect of their jobs.
- 87% of case managers rated documentation and administrative requirements in the following way - "(paperwork) *is a major burden and it interferes with service provision*".
- Supervisors listed paperwork burdens as an important area in which to improve case management services.
- The term "paperwork" applies to numerous issues. OIG staff note that there are multiple sources of documentation and administrative burdens, including DMHMRSAS licensure and performance contract requirements, DMAS requirements (especially those of the waivers), agency-specific requirements, and administrative tasks required to procure or manage services from other agencies on behalf of clients (DSS, DRS, transportation, medical, housing, charities, etc.). Complaints abound about the poor coordination of all

these requirements, the need to enter the same information repeatedly, the lack of efficient electronic processing, and the presumed and real costs or penalties for errors.

Quality of Care Recommendation E.4: It is recommended that DMHMRSAS, DMAS, and CSBs review and amend their respective regulations, documentation requirements, and inspection procedures to seek ways to streamline, standardize, and minimize data and record keeping requirements in an effort to allow case managers to maximize the amount of time they are available to the persons they serve.

DMHMRSAS Response: *Consistency across communities, providers, investigators and consultants is a goal of the PCP Leadership Team. It is reviewing and commenting on needed changes to regulations, documentation requirements and inspection activities that will reduce duplication, ease access to services and facilitate the availability of time case managers have to spend with the individuals they support. Comments have been made on the Human Rights and Licensing regulations, and the team is currently working on the MR Waiver, Omnibus and DS regulations. The compilation of all essential information/data elements needed by CSBs, private providers, DMHMRSAS and DMAS for helping individuals with intellectual disabilities to access and utilize services and supports, assure health and safety and comply with all relevant regulations is nearing completion and ready for field testing, along with the new planning process (see response to Recommendation B.6.b). Simple tools for organizations and reviewers to assess person-centered practices are being developed and field tested also. All of these efforts should simplify communication and navigation of the service and funding systems and enable case managers to spend more quality time with individuals and families.*

Quality of Care Finding E.5: Salaries for CSB case managers at some CSBs are very low. This contributes to staff turnover that interferes with continuity of care.

- The entry-level salary for CSB mental retardation case managers ranges from $22,848 at Cumberland Mountain CSB to $45,878 at Fairfax-Falls Church CSB. The average entry-level case manager salary statewide is $31,823. See Attachment H for salary information by CSB.
- The average current salary for CSB mental retardation case managers ranges from $26,116 at Planning District 1 CSB to $64,039 at Fairfax-Falls Church CSB. The average current salary statewide for case managers is $36,744. See Attachment H for salary information by CSB.
- Case managers often noted in interviews with OIG inspectors that low salaries are a concern and one reason why many case managers find it difficult to stay in the role for many years. A common reference point for a public-sector employee with a bachelor's degree is the public school teacher. The following comparison between CSB case manager and public school teacher salaries indicates that case manager salaries lag behind teachers:

Average Annual salaries	CSB Case Managers	Public School Teachers (converted to full year schedule – 234 days)
Starting salaries	**$31,823**	**$40,397**
Salaries of current employees	**$36,744**	**$57,871**

  - For the school year 2006-2007, the average salary for all teachers was $49,252 (based on a school year calendar of 200 working days). (Source – Virginia Department of Education) When this figure is adjusted to the average number of working days experienced by case managers (234 – based on state employee averages), the comparable salary for experienced teachers is $57,871.
  - The average entry level salary for teachers in 2006 was $34,527 (based on a school year calendar of 200 working days). (Source: Virginia Education Association). When this figure is adjusted to the average number of working days experienced by case managers (234 – based on state employee averages), the comparable salary for experienced teachers is $40,397.
  - While at starting level case managers pay is 79% of starting teacher salaries, the gap increases for experienced employees. Experienced case managers pay averages are only 63.5% of experienced teachers'.
- Only a handful of CSBs offer career path promotional opportunities for persons who desire to remain case managers.

Quality of Care Recommendation E.5: It is recommended that each CSB conduct a review to determine if current salary ranges for case managers are having any negative impact on continuity of care for persons who receive case management services and develop strategies to address any problems that are identified.

DMHMRSAS Response: *DMHMRSAS will provide support to the CSBs, through its work with the MR Council and the regional case management committees, as they conduct local studies designed to determine the presences of negative impacts on services to individuals resulting from current case management salary ranges. DMHMRSAS will help facilitate a report to the Inspector General's Office from the CSBs on the results of this study by 12/31/08.*

Section V

Appendix

A. Quality Statements and Indicators

B. Number of Adults Receiving Mental Retardation Case Management Services

C. Models for Delivery of Mental Retardation Case Management Services

D. Access to Mental Retardation Case Management Services

E. Case Management Face to Face Contacts During 90 day Period by Location

F. Average Case Management Caseloads Reported by CSBs

G. Case Manager Education/Licensure

H. Salaries for CSB Mental Retardation Case Managers

I. MR Training Center Survey of CSB MR Case Management Services

J. Survey Questionnaires and Checklists
(Actual documents are available with the website version of this report found at www.oig.virginia.gov)

1. Case Manager Interview
2. CSB Adult Mental Retardation Case Management Record Review
4. Supervisor Interview
5. Survey of Adult Mental retardation Case Management Services
6. Family/Residential Provider Interview
7. Training Center Survey of Case Management Activity

Attachment A

Mental Retardation Case Management
Quality Statements and Indicators

1. Case management services are person-centered and person-driven.

- Persons and their families have choice in receiving case management services and in selecting or changing case managers.
- Case management and service plans reflect the person's needs and goals and are developed by the person, working with the case manager.
- Case managers have received training in self determination and person-centered planning.
- Case management records and procedures reflect and support person-centered planning and service models.
- Case managers embrace and demonstrate the values and principles of self determination and the person-centered planning model.
- The plan and services provided are responsive to the person's needs, strengths, and goals.

2. Case management coordinates needed supports in a comprehensive manner, affording the person and his or her family the greatest possible choice among providers and services.

- The case manager identifies resources, arranges for needed services, and coordinates services according to the person's needs and plans.
- The medical care needs of persons are closely monitored and services are arranged and coordinated as required.
- Case management services work closely with residential and day support services to provide a coordinated package of support services.
- Case managers monitor and evaluate the provision of services needed by the persons they serve.
- Case managers advocate for the needs of the persons they serve and contribute to the CSB's responsibility to plan and develop needed mental retardation and community services.
- Case management services are appropriately supportive of the persons they serve during periods of crisis and facility-based services.

3. Case managers and the persons they serve share a constructive interpersonal helping connection that fosters trust, cooperation and support for each person's pathway to greater independence and self determination.

- Persons served and their families feel that their case managers listen to them and respect their choices.

- The case management relationship is characterized by continuity of care, including reliable, long-term tenure of the person served-case manager relationship with minimal interruption and change due to turnover and reorganization.
- Case managers and the persons they serve share and agree on assessment of needs, services, and the value of services provided.
- Persons and their families value the case management services they receive.
- Persons and their families have convenient and timely access to their case managers.

4. Case management is an active, positive service that reaches out to the persons they serve and provides continuing, active supports.

- Case management is a vigorous, active service, with frequent face-to-face and collateral contacts provided at a level sufficient to assure positive outcomes, guided by the preferences of those served and their families.
- The majority of case management services are provided on an outreach basis, out in the community at locations preferred by the persons they serve.
- Caseload sizes are of the optimum size to allow thorough, comprehensive case management services based on each person's needs and preferences.
- The CSB is able to employ sufficient numbers of case managers to assure appropriate caseload sizes and effective services.
- High quality case management services are available to all persons who need such services, regardless of their ability to pay for them.

5. Case managers are qualified, well prepared, and supported in their roles.

- Case managers have the required knowledge, skills and abilities to provide case management services.
- Case managers receive active, ongoing training in topics that are specific to the varied demands of the case management role, including case management skills, dual diagnosis needs, service resources, assessment and coordination of medical needs, cultural competence, etc.
- Documentation requirements, provision of technological supports (computers, electronic records, etc.), and provision of other supports (agency vehicles, for example) support and enable efficient and effective case management services.
- CSBs are able to recruit and retain qualified case managers.
- Case managers enjoy their jobs and receive professional stimulation and gratification from their work with the persons they serve.
- Case managers feel their services are valued and respected by their professional colleagues.

Attachment B

Number of Adults Receiving Mental Retardation Case Management Services			
CSB	**Population**	**Number Served**	**% of Total Population Receiving Adult MR CM Services**
Alexandria	132,176	135	0.10%
Alleghany High	22,757	58	0.25%
Arlington	191,623	238	0.12%
Blue Ridge	243,626	446	0.18%
Central Virginia	234,140	513	0.22%
Chesapeake	214,145	305	0.14%
Chesterfield	289,568	696	0.24%
Colonial	145,150	161	0.11%
Crossroads	99,585	171	0.17%
Cumberland Mt	97,305	301	0.31%
Danville-Pitt	106,907	289	0.27%
Dickenson	16,226	19	0.12%
District 19	169,419	375	0.22%
Eastern Shore	52,000	125	0.24%
Fairfax-Falls Church	1,042,781	1,512	0.14%
Goochland-Pow	45,818	83	0.18%
Hampton-NN	326,502	509	0.16%
Hanover	95,476	205	0.21%
Harrisonburg-Rock	115,126	237	0.21%
Henrico Area	306,041	671	0.22%
Highlands	69,184	120	0.17%
Loudoun	262,726	185	0.07%
Middle Pen-NN	137,316	225	0.16%
Mt. Rogers	119,014	267	0.22%
New River Valley	167,915	139	0.08%
Norfolk	235,071	426	0.18%
Northwestern	206,470	306	0.15%
PD One	93,637	189	0.20%
Piedmont	137,922	243	0.18%
Portsmouth	98,514	208	0.21%
Prince William	412,894	468	0.11%
Rappahannock Area	301,831	486	0.16%
Rappahannock-Rap	156,737	208	0.13%
Region Ten	216,153	337	0.16%
Richmond	191,740	579	0.30%
Rockbridge Area	39,598	87	0.22%
Southside	86,625	227	0.26%
Valley	113,797	302	0.27%
Virginia Beach	433,470	687	0.16%
Western Tidewater	137,341	345	0.25%

Attachment C

Models for Delivery of Mental Retardation Case Management Services					
	MR Case Management is stand alone service composed only of MR CM	MR and MH Case Management are one team but staff are MH CM or MR CM, not both	MH and MR Case Management are on one team and staff do both MH CM and MR CM	CSB employs levels or tiers of case management classification based on case management need	CSB employs caseload limit or cap
Alexandria	x			x	x
Alleghany Highlands	x			x	x
Arlington	x			x	
Blue Ridge	x			x	
Central Virginia	x				
Chesapeake	x				
Chesterfield	x			x	x
Colonial	x			x	
Crossroads	x			x	
Cumberland Mountain	x				x
Danville-Pittsylvania	x				
Dickenson	x				
District 19	x			x	x
Eastern Shore	x			x	
Fairfax-Falls Church	x			x	x
Goochland-Powhatan		x		x	
Hampton-Newport News	x				
Hanover County	x			x	
Harrisonburg-Rockingham	x			x	
Henrico Area	x			x	
Highlands	x				x
Loudoun	x			x	
Middle Peninsula-NN	x				
Mt. Rogers	x			x	x
New River Valley		x		x	x
Norfolk	x			x	x
Northwestern		x		x	
Piedmont	x				
Planning District One	x			x	x
Portsmouth	x				x
Prince William	x			x	x
Rappahannock Area		x		x	x
Rappahannock-Rapidan	x			x	
Region Ten		x		x	x
Richmond Behavioral H. A.	x				
Rockbridge Area			x		x
Southside		x			x
Valley	x			x	x
Virginia Beach	x				x
Western Tidewater	x			x	x

Attachment D

Access to Mental Retardation Case Management Services			
	Time from first call to CSB to first meeting with CM (days)	CSB uses wait list for CM / # waiting/ wait time (days)	Time from referral to first appt. with psychiatrist
Alexandria	14		21
Alleghany Highlands	10		28
Arlington	Varies		42
Blue Ridge	28		42
Central Virginia	90		84
Chesapeake	42		252
Chesterfield	7		30
Colonial	Varies	Yes/ 8/ not provided	13
Crossroads	14	Yes/ 3/ 84 days	25
Cumberland Mountain	14		42
Danville-Pittsylvania	11		21
Dickenson	7		18
District 19	28		18
Eastern Shore	18		14
Fairfax-Falls Church	45	Yes/ 107/ 840 days	18
Goochland-Powhatan	9		30
Hampton-Newport News	45		7
Hanover County	Varies		18
Harrisonburg-Rockingham	21		21
Henrico Area	47		21
Highlands	10		30
Loudoun	25	Yes/ 60 / 728 days	42
Middle Peninsula-NN	42		30
Mt. Rogers	7		44
New River Valley	7		42
Norfolk	7		30
Northwestern	7	Yes 7 /not provided	14
Piedmont	18		35
Planning District One	7		21
Portsmouth	14		7
Prince William	Varies	Yes/ 108 / 252 days	20
Rappahannock Area	7		21
Rappahannock-Rapidan	30		42
Region Ten	7		30
Richmond Behavioral H. A.	Varies		6
Rockbridge	30		30
Southside	14		21
Valley	120		42
Virginia Beach	42	Yes /13 / 90 days	Not provided
Western Tidewater	14	Yes/ 9 / 10.5 days	14

Attachment E

Case Management Face to Face Contacts During 90 Day Period by Location					
Community Services Board	**Average Face to Face Visits During 90 Day Period**	**Percentage in the Office**	**Percentage in the Day Program**	**Percentage in the Community (Medical Social Service, etc.)**	**Percentage in the Person's Residence**
Alexandria	2.4	0%	42%	5%	53%
Alleghany Highlands	Not Visited				
Arlington	2.1	0%	12%	0%	88%
Blue Ridge	1.8	36%	14%	0%	50%
Central Virginia	4	25%	31%	16%	28%
Chesapeake	Not Visited				
Chesterfield	1.6	20%	32%	0%	48%
Colonial	2.1	6%	71%	6%	18%
Crossroads	3.1	36%	20%	20%	24%
Cumberland Mountain	Not Visited				
Danville-Pittsylvania	2.3	11%	39%	22%	28%
Dickenson	Not Visited				
District 19	3.9	26%	48%	10%	16%
Eastern Shore	Not Visited				
Fairfax-Falls Church	1.1	6%	59%	9%	26%
Goochland-Powhatan	3.5	11%	43%	29%	18%
Hampton-Newport News	1.5	5%	64%	5%	27%
Hanover County	Not Visited				
Harrisonburg-Rockingham	Not Visited				
Henrico Area	Not Visited				
Highlands	1.6	0%	155	46%	38%
Loudoun	1.3	0%	40%	20%	40%
Middle Peninsula-NN	1.3	8%	58%	0%	33%
Mt. Rogers	Not Visited				
New River Valley	4.4	51%	0%	14%	34%
Norfolk	2.4	0%	5%	21%	74%
Northwestern	3.3	8%	54%	23%	15%
Piedmont	3.3	4%	77%	0%	19%
Planning District One	3	4%	17%	17%	62%
Portsmouth	Not Visited				
Prince William	2.3	6%	62%	12%	21%
Rappahannock Area	1.4	27%	55%	9%	9%
Rappahannock-Rapidan	1.9	0%	53%	13%	33%
Region Ten	1.6	8%	31%	15%	46%
Richmond Behavioral H.A.	Not Visited				
Rockbridge Area	Not Visited				
Southside	2.1	12%	35%	0%	53%
Valley	3.6	7%	45%	17%	31%
Virginia Beach	1.9	27%	39%	21%	11%
Western Tidewater	2.1	205	67%	7%	7%

Attachment F

Average Case Management Caseloads Reported by CBSs		
1st Quartile	Dickenson	19.0
	New River Valley	21.9
	Alleghany Highlands	22.3
	Rockbridge Area	23.2
	Northwestern	23.5
	Alexandria	26.7
	Goochland Powhatan	27.7
	Arlington	28.0
	Middle Peninsula Northern Neck	28.1
	Portsmouth	29.1
2nd Quartile	Virginia Beach	29.5
	Loudoun	29.8
	Region Ten	31.2
	Eastern Shore	31.3
	Planning District 1	31.5
	Norfolk	31.8
	Southside	32.4
	Highlands	32.4
	Valley	33.6
	Colonial	33.9
3rd Quartile	Hampton-Newport News	33.9
	Hanover	34.2
	Piedmont	34.7
	Richmond	35.6
	Prince William	36.0
	Danville-Pittsylvania	36.1
	Crossroads	36.4
	Chesterfield	37.6
	Harrisonburg-Rockingham	37.9
	Cumberland Mountain	38.8
4th Quartile	Chesapeake	39.8
	Henrico	40.0
	Mount Rogers	40.2
	Blue Ridge	41.9
	Fairfax-Falls Church	43.8
	Rappahannock Area	44.2
	Central Virginia	44.5
	Western Tidewater	46.0
	Rappahannock Rapidan	46.2
	District 19	46.9

Attachment G

Case Manager Education/Licensure											
	Nurses		Licensed		Master's		Bachelor's		< Bachelor's		Total
	#	%	#	%	#	%	#	%	#	%	
Alexandria	0	0%	0	0%	2	33%	4	67%	0	0%	6
Alleghany Highlands	1	25%	0	0%	0	0%	1	25%	2	50%	4
Arlington	0	0%	0	0%	2	25%	5	63%	1	13%	8
Blue Ridge	1	7%	1	7%	1	7%	6	43%	5	36%	14
Central Virginia	0	0%	0	0%	3	21%	10	71%	1	7%	14
Chesapeake	0	0%	0	0%	3	27%	6	55%	2	18%	11
Chesterfield	0	0%	0	0%	5	24%	16	76%	0	0%	21
Colonial	0	0%	0	0%	2	33%	4	67%	0	0%	6
Crossroads	0	0%	0	0%	0	0%	4	80%	1	20%	5
Cumberland Mountain	0	0%	0	0%	1	11%	8	89%	0	0%	9
Danville-Pittsylvania	0	0%	0	0%	0	0%	7	88%	1	13%	8
Dickenson County	0	0%	0	0%	0	0%	1	100%	0	0%	1
District 19	0	0%	0	0%	0	0%	11	100%	0	0%	11
Eastern Shore	0	0%	0	0%	1	25%	1	25%	2	50%	4
Fairfax-Falls Church	0	0%	2	3%	14	23%	44	73%	0	0%	60
Goochland-Powhatan	1	25%	0	0%	0	0%	2	50%	1	25%	4
Hampton-Newport News	0	0%	0	0%	1	7%	14	93%	0	0%	15
Hanover County	0	0%	0	0%	3	38%	4	50%	1	13%	8
Harrisonburg-Rockingham	0	0%	0	0%	1	14%	5	71%	1	14%	7
Henrico Area	0	0%	0	0%	2	8%	21	88%	1	4%	24
Highlands	0	0%	0	0%	0	0%	5	100%	0	0%	5
Loudoun	0	0%	0	0%	2	25%	6	75%	0	0%	8
Middle Peninsula-NN	0	0%	0	0%	0	0%	7	78%	2	22%	9
Mt. Rogers	0	0%	0	0%	2	18%	4	36%	5	45%	11
New River Valley	0	0%	0	0%	1	9%	10	91%	0	0%	11
Norfolk	0	0%	0	0%	0	0%	16	100%	0	0%	16
Northwestern	0	0%	0	0%	1	8%	6	46%	6	46%	13
Piedmont	0	0%	0	0%	1	10%	9	90%	0	0%	10
Planning District One	0	0%	0	0%	0	0%	5	71%	2	29%	7
Portsmouth	0	0%	0	0%	1	13%	7	88%	0	0%	8
Prince William	0	0%	0	0%	3	27%	7	64%	1	9%	11
Rappahannock Area	0	0%	0	0%	0	0%	8	73%	3	27%	11
Rappahannock-Rapidan	0	0%	0	0%	0	0%	6	100%	0	0%	6
Region Ten	0	0%	0	0%	2	18%	5	45%	4	36%	11
Richmond Behavioral	0	0%	0	0%	5	31%	11	69%	0	0%	16
Rockbridge Area	1	20%	0	0%	0	0%	3	60%	1	20%	5
Southside	0	0%	0	0%	1	13%	5	63%	2	25%	8
Valley	0	0%	0	0%	2	18%	9	82%	0	0%	11
Virginia Beach	0	0%	4	10%	11	27%	26	63%	0	0%	41
Western Tidewater	0	0%	0	0%	3	38%	5	63%	0	0%	8
Total	4	1%	7	2%	76	16%	334	72%	45	10%	466

Attachment H

Salaries for Case Managers at the CSBs								
	Starting Salary	**Current Average Salary**			**Ranking of Starting Salary**			**Ranking of Current Average Salary**
Alexandria	$37,868	$47,826		Fairfax-Falls Church	$45,878		Fairfax-Falls Church	$64,039
Alleghany Highlands	$27,821	$33,176		Prince William	$44,882		Prince William	$57,263
Arlington	$42,723	$52,304		Arlington	$42,723		Loudoun	$53,471
Blue Ridge	$28,101	$33,614		Rappahannock Area	$39,650		Arlington	$52,304
Central Virginia	$29,330	$32,110		Virginia Beach	$37,915		Alexandria	$47,826
Chesapeake	$35,499	$37,634		Alexandria	$37,868		Henrico Area	$44,627
Chesterfield	$37,440	$37,717		Chesterfield	$37,440		Rappahannock Area	$44,354
Colonial	$29,154	$33,250		Henrico Area	$36,717		Virginia Beach	$43,000
Crossroads	$32,576	$34,225		Loudoun	$36,500		Region Ten	$41,290
Cumberland Mountain	$22,848	$28,175		Chesapeake	$35,499		Richmond	$39,750
Danville-Pittsylvania	$30,719	$35,679		Hanover County	$35,265		Hanover County	$37,950
Dickenson County	$26,904	$34,000		Richmond	$35,144		Chesterfield	$37,717
District 19	$30,076	$33,621		Region Ten	$34,648		Goochland-Powhatan	$37,704
Eastern Shore	$27,792	$29,695		Rappahannock-Rapidan	$34,515		Chesapeake	$37,634
Fairfax-Falls Church	$45,878	$64,039		Crossroads	$32,576		Danville-Pittsylvania	$35,679
Goochland-Powhatan	$32,201	$37,704		Hampton-Newport News	$32,544		Portsmouth	$34,746
Hampton-Newport News	$32,544	$32,756		Goochland-Powhatan	$32,201		Rappahannock-Rapidan	$34,690
Hanover County	$35,265	$37,950		Norfolk	$31,504		Mt. Rogers	$34,560
Harrisonburg-Rock'hm	$28,308	$33,744		Portsmouth	$31,411		Crossroads	$34,225
Henrico Area	$36,717	$44,627		Danville-Pittsylvania	$30,719		Dickenson County	$34,000
Highlands	$29,437	$32,000		District 19	$30,076		Harrisonburg-Rock'hm	$33,744
Loudoun	$36,500	$53,471		Southside	$29,821		District 19	$33,621
Middle Peninsula-NN	$27,171	$28,497		Highlands	$29,437		Blue Ridge	$33,614
Mt. Rogers	$25,758	$34,560		Central Virginia	$29,330		Norfolk	$33,296
New River Valley	$28,874	$31,266		Western Tidewater	$29,253		Colonial	$33,250
Norfolk	$31,504	$33,296		Colonial	$29,154		Alleghany Highlands	$33,176
Northwestern	$26,583	$27,078		New River Valley	$28,874		Southside	$32,888
Piedmont	$25,122	$27,576		Harrisonburg-Rock'hm	$28,308		Western Tidewater	$32,784
Planning District One	$23,670	$26,116		Blue Ridge	$28,101		Hampton-Newport News	$32,756
Portsmouth	$31,411	$34,746		Alleghany Highlands	$27,821		Central Virginia	$32,110
Prince William	$44,882	$57,263		Eastern Shore	$27,792		Highlands	$32,000
Rappahannock Area	$39,650	$44,354		Middle Peninsula-NN	$27,171		New River Valley	$31,266
Rappahannock-Rapidan	$34,515	$34,690		Dickenson County	$26,904		Valley	$31,124
Region Ten	$34,648	$41,290		Rockbridge Area	$26,791		Rockbridge Area	$30,180
Richmond	$35,144	$39,750		Northwestern	$26,583		Eastern Shore	$29,695
Rockbridge Area	$26,791	$30,180		Mt. Rogers	$25,758		Middle Peninsula-NN	$28,497
Southside	$29,821	$32,888		Piedmont	$25,122		Cumberland Mountain	$28,175
Valley	$24,500	$31,124		Valley	$24,500		Piedmont	$27,576
Virginia Beach	$37,915	$43,000		Planning District One	$23,670		Northwestern	$27,078
Western Tidewater	$29,253	$32,784		Cumberland Mountain	$22,848		Planning District One	$26,116

Attachment I

MR Training Center Survey of CSB MR Case Management Services

1=Strongly Agree 2= Agree 3=Disagree 4=Strongly Disagree 5=Not sure/unknown

	Alex	All-Hi	Arlin	BR	CenV	Chespk	Chesfld	Col	Cross	Cumb	Da-P	Dick
A contact person is established by the CSB for each resident at the TC from that CSB.	2	2	2	2	4	1	1	1	1	1	2	1
The CSB contact person is knowledgeable about the resident.	2	4	2	3	4	2	1	2	2	2	4	2
The contact person is the resident's case manager	2	4	2	4	4	2	1	2	1	1	4	2
The CSB contact or CM is accessible and responsive to call and emails from the TC	1	4	2	2	4	2	2	2	2	1	2	2
The CSB contact or CM visits the resident at the TC.	3	4	3	3	4	1	3	2	3	1	3	2
The CSB contact or CM attends the annual plan meetings.	3	4	3	3	4	1	3	2	3	3	3	5
The CSB provides active assistance in planning and arranging for services in the community when residents near discharge.	1	4	1	2	4	2	2	2	2	2	4	1
The CSB contact or CM is in contact with the residents' families or ARs.	3	4	3	3	3	5	1	5	1	5	4	5
The CSB contact or CM serves as an advocate for the resident.	2	3	2	2	3	2	1	2	1	1	2	2
Turnover of case managers is a problem for the residents and staff at the TC.	3	5	3	1	1	2	4	2	4	3	3	3
Overall, the TC is satisfied with the level of support and involvement provided by the CSB's CM program for residents of the TC.	2	4	2	3	4	2	2	2	2	1	4	1

MR Training Center Survey of CSB MR Case Management Services

1=Strongly Agree 2= Agree 3=Disagree 4=Strongly Disagree 5=Not sure/unknown

	PD19	ES	F-FC	Gooch	H-NN	Han	H-R	Henr	High	Loud	MPNN
A contact person is established by the CSB for each resident at the TC from that CSB.	1	1	2	1	1	1	2	1	1	2	1
The CSB contact person is knowledgeable about the resident.	1	2	2	2	2	2	4	1	2	2	2
The contact person is the resident's case manager	1	2	2	1	2	2	4	1	5	2	2
The CSB contact or CM is accessible and responsive to call and emails from the TC	2	2	2	2	2	2	4	1	1	2	2
The CSB contact or CM visits the resident at the TC.	3	3	3	3	2	3	4	2	1	2	2
The CSB contact or CM attends the annual plan meetings.	2	3	3	3	2	3	4	2	3	2	2
The CSB provides active assistance in planning and arranging for services in the community when residents near discharge.	2	2	1	2	2	2	4	1	2	2	2
The CSB contact or CM is in contact with the residents' families or ARs.	2	5	3	1	5	1	4	1	3	3	5
The CSB contact or CM serves as an advocate for the resident.	2	2	2	1	2	1	4	1	2	2	2
Turnover of case managers is a problem for the residents and staff at the TC.	4	2	2	4	2	4	5	4	3	3	2
Overall, the TC is satisfied with the level of support and involvement provided by the CSB's CM program for residents of the TC.	2	2	2	2	2	2	4	1	2	2	2

MR Training Center Survey of CSB MR Case Management Services

1=Strongly Agree 2= Agree 3=Disagree 4=Strongly Disagree 5=Not sure/unknown

	Mt. R	NRV	Norfk	NW	PD1	Pied	Port	PWC	R-R	RappA	RBHA	RTen	Rock	SS	Val	VB	WesT
A contact person is established by the CSB for each resident at the TC from that CSB.	1	1	1	2	1	2	1	2	2	2	1	1	2	1	2	1	1
The CSB contact person is knowledgeable about the resident.	2	1	2	2	2	4	2	2	4	2	1	2	4	1	2	2	2
The contact person is the resident's case manager	2	1	2	4	2	4	2	3	4	2	1	2	4	1	2	2	2
The CSB contact or CM is accessible and responsive to call and emails from the TC	2	1	2	1	2	2	2	2	2	4	1	2	4	1	2	2	2
The CSB contact or CM visits the resident at the TC.	5	1	2	2	2	3	2	2	4	2	1	2	4	1	2	2	2
The CSB contact or CM attends the annual plan meetings.	5	2	2	3	5	3	2	2	4	3	1	3	4	1	2	1	2
The CSB provides active assistance in planning and arranging for services in the community when residents near discharge.	2	1	2	1	1	2	2	2	4	3	1	2	4	1	3	2	2
The CSB contact or CM is in contact with the residents' families or ARs.	3	3	5	2	5	3	5	3	3	3	1	2	4	1	3	5	5
The CSB contact or CM serves as an advocate for the resident.	2	1	2	2	2	3	2	2	3	3	1	1	4	1	2	2	2
Turnover of case managers is a problem for the residents and staff at the TC.	3	3	2	3	3	3	2	3	3	2	4	3	5	4	3	3	2
Overall, the TC is satisfied with the level of support and involvement provided by the CSB's CM program for residents of the TC.	2	1	2	3	1	3	2	2	4	4	1	2	4	1	3	2	2

Attachment J **Survey Questionnaires and Checklists:**

Office of the Inspector General
CSB Adult Mental Retardation Case Manager Record Review

Case Management CSB _____ Name of Person Served:

Reviewer _____ Name of Case Manager:
Date _____

Check one: Active case management _____ Inactive or Monitoring _____

Date for start of the quarter: _____ (Count back three months from today, start at this point in progress note reviews.)

1. **Value: The person receiving services has maximum control of the development of his own need assessment and Comprehensive Services Plan (CSP) and Case Management ISP.** (Do not evaluate the residential or day support ISPs. You may have to go back more than one quarter to find the last complete annual plans. See 90 day reviews that update the plan. Select (check) the one rating option that most closely fits what the plan shows with regard to choice and self-determination:

There is little or no record of the person's involvement with the ISP. The assessment and the plan
are professionally driven, deficit based, and assume the person needs to be fixed. Preferences, likes,
and dislikes, if present, are an add-on. Services are designed to change the person.

_____

There is evidence that the case manager elicited and received input from the consumer about the plan.
Professionally driven, but with some valued input by the person. There is a focus on the person's interests, preferences and capabilities. Preferences are addressed and reflected in actual supports and service selections. A shared effort.
Services and supports mostly may seem designed to change the person, but some services may show efforts to support or accommodate the person's needs or preferences.

_____

The plans are judged to be substantially driven by the person, a self-directed plan, with the case manager in a support role.
The plans are clearly the expression of the consumer's wishes and preferences. The consumer's own words or otherwise

expressed vision are the heart of the plan. Services are designed to support, not change the person. _____

There is no case management or other current service plan (may occur with Inactive/Monitoring status) _____

How many ***face-to-face*** contacts did the case manager have with the person in the last three months, and where did they occur?

Record number of documented face-to-face contacts, by location: (There should be a progress note section. There may be a monthly summary that documents all individual contacts, place, nature, duration, etc.)

Number Tally (use this space to count contacts with slash marks, put total under Number column.)

_____ _____ in the case managers office or the case management office building (e.g. in the waiting room, etc.)

_____ _____ at a day support program

_____ _____ out in the community, e.g., restaurant, store, doctor visit

_____ _____ in the consumer's residence.

_____ Total face-to-face in the last three months (sum of the above, for the quarter)

2. How many other contacts did the case manager have with the person ***directly*** (not face to face, but not with a surrogate. by phone) in the last quarter?

Number Tally
_____ _____ total other direct contacts in the last three months

3. How many contacts did the case manager have with the consumer's family or authorized representative.

Number Tally
_____ _____ total family or AR contacts in the last three months

4. Evidence that the case manager engaged in the following activities in the last quarter See progress notes, monthly summaries. (check all that apply) *(*see Key, below for definitions)*: For Inactive/Monitoring cases, comment below. What is status of person (in special ed, at training center, does not need/want CM, etc.

arrangement of medical services	
linkage or coordination of other services	
contact with residential service provider	
contact with day support provider	
evaluation of services received by consumer	
advocacy for consumer	
supportive counseling	
crisis support services	

5. Stakeholders:

(Print legibly)
Name of family member/Legal Guardian/Authorized Representative **(circle which)**_____Relationship_____

Day phone _____PM phone _____

Street address, city,

zip_____

_____

(Do not complete the next two items for inactive/monitoring cases)

Residential support provider agency:_____ Contact person _____

Day phone_____

Street address, city,

zip_____

_____

Day support provider agency:_____ Contact person _____

Day phone_____

Street address, city,

zip_____

_____

***Key:** **Arrangement of medical services** is making appointments, taking consumer to appointments, completing benefits paperwork, contact with medical provider

Linkage or coordination of other services refers to social services, DRS, training centers, schools – anything other than medical, residential, or day support

Contact with residential services or day support services providers. These may be where the resident lives or works, or possible future service arrangements

Evaluation of services. CM conducts inspections, notes problems during visits, reviews residential and day support records, etc.

Advocacy. CM clearly takes a position on behalf of client, speaks up for client, intercedes on his/her behalf. This might not be common in a given quarter.

Supportive counseling. CM documents provision of support and guidance on emotional, relationship, or behavioral issues**.**

Crisis support. CM documents role in assisting with crisis (psychiatric issues, housing emergency, medical, behavioral, etc.)

Office of the Inspector General
CSB Adult Mental Retardation Case Management Review
Supervisor Interview

Case Management CSB: _____

Reviewer: _____ Respondent: _____

Date: _____ Phone: _____

Respondent: (circle one)

Case Management Supervisor Division director Executive Director

1. How long have you been in a position that supervises adult mental retardation case management services at this CSB? _____years

2. How often do you *expect* your case managers to see each person face-to-face?

   ____every 90 days____monthly____every other week ___weekly
   ___no specific expectation

3. How often do you *expect* your case managers to make other direct contact (telephone) with the person?

   ____every 90 days____monthly____every other week ___weekly
   ____no specific expectation

4. How often do you *expect* your case managers to make other direct contact (telephone) with the person's family or AR?

   ____every 90 days____monthly____every other week ___weekly __no specific expectation

5. What is your expectation of where case managers see their clients?

   How often do you require them to visit the person's home?

   How often do you require them to visit the person's day support?

   Comments:

6. What are the differences, if any, in active case management received by persons who have Medicaid and qualify for TCM and those who do not?

   What additional differences are present for persons with Medicaid waiver programs?

7. Do you have a tier of service that is less intensive, often called tracking, follow along, monitoring, or inactive?
   ___ yes, we have inactive or monitoring case loads
   ____ no, we do not have an inactive or monitoring status.

   If yes, what are its entrance requirements, minimum service expectations, and typical level of activity?

   Do your regular case managers also carry these cases?

8. Is turnover of case managers a problem at your CSB? Why or why not?

9. What do you do to assure or increase choice and self-determination in the planning and provision of case management services for persons? *This is for case management as a service itself, not the choice of providers – that comes next.*

10. What do you do to assure or increase consumer and family choice among providers (residential, day support)? If your CSB operates residential or day support services, do you do anything special to assure objective choice among providers for persons and their families?

11. Do you assign case managers to persons in the training center? What are your expectations for the level and frequency of contact and other services with persons in the training centers?

12. What provision is made for consumers to reach their case manager or a backup (not just ES) on evenings, weekends, holidays, or vacations?

13. Does the name “case management” accurately describe the services your case managers provide? What would be a better name? Do you use a different term?

14. What do you do to assess or measure competence in all the skills that a case manager must have?

15. What do you do to contact and assist persons and their families about transitioning from special education or CSA services into case management and access to community support services?

16. What do you do to measure the quality and customer satisfaction of the case management services you provide?

17. What should be the target caseload size for a full time mental retardation case manager in Virginia? If you have active and inactive service statuses, show levels for each for a full time case manager.

18. What do you do to prepare case managers for the roles of program evaluator, service monitor, and advocate – skills they are not likely to have learned in academic training or other jobs.

19. What one or two changes do you think are most needed to improve case management services in Virginia?

Office of the Inspector General

CSB Adult Mental Retardation Case Management Review

Case Manager Interview

Case Management CSB:	
Date:	

Question				
1	How long have you been a case manager with this team, serving the same caseload, essentially the same persons?			
2	How many hours per week that you are assigned to work as a case manager: (if full time put down 40 hours).			
3	How many persons do you serve *right now* for case management (caseload size). Include "extra" persons if you are filling in for a staff vacancy.	# active	# inactive/monitoring	
4	Of this number (your current caseload size, number 3, above) You may, and probably will, put some persons in more than one category.			
a	How many persons are below age 18?			
b	How many have dual mental health and mental retardation diagnoses?			
c	How many present significant behavioral challenges that require intervention?			
d	How many have DD conditions, but not MR (e.g., autism, DD waiver)?			
e	How many reside in an Assisted Living Facility (licensed by DSS)			
f	How many reside in a state training center?			
5	What percentage of your time each week is taken up by documentation requirements (paperwork).			
6	**Indicate your agreement with the following statements:**			

	Statements	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
a	My caseload size is too large for me to do all that I think is needed for the people I serve.				

b	My agency provides the training I need to be as effective a case manager as possible.				
c	The expectations placed on me as a case manager are clear and consistent.				
	Statements	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
d	I find being a case manager professionally stimulating and satisfying.				
e	I feel safe working out in the community or in the homes of the people I serve.				
f	The paperwork I must maintain is a major burden and it interferes with service provision.				
g	My role as a case manager is respected by program staff and agencies with whom I work.				
h	Our agency allows consumers enough choice and self-determination in selecting their services.				
i	My agency has provided case managers with specific training regarding person centered planning and self-determination within the past year.				
j	I am well prepared by training or experience to deal with co-occurring mental health disorders among the persons I serve.				
k	I am well prepared by training and agency supports to relate to the cultural diversity of my clients (e.g., race, language, etc.)				
l	I am well prepared by training and experience to assess and coordinate the health care needs of the persons I serve.				
m	I am well prepared by training and support from my agency to monitor the quality of services received by the persons in my caseload.				
n	I am well prepared by training and support from my agency to advocate for the persons I serve, for example, when I feel other service providers are not meeting my client's needs.				
o	The persons I serve who do not have families or authorized representatives to supervise their care are adequately capable to make decisions about their needs.				
p	Finding persons to serve as authorized representatives or guardians is a big problem.				
q	I feel pressure to guide consumer and family choices to the residential or day support services operated by my own CSB rather than other providers. (If your CSB does not offer such services, leave blank.)				

r	Family members or authorized representatives usually make good decisions about choice of services for the persons I serve.				
s	CSPs and case management ISPs are driven by the personal choices and preferences of the persons I serve.				
t	The CSPs are developed and based on a planning meeting that featured active, knowledgeable input from the consumer, family or AR, and relevant providers.				
u	There is a sufficient array of residential and day support services in my area to provide appropriate choice and services for most of the persons I serve.				
v	My case management team has good morale.				
	Statements	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
w	Mental health and mental retardation services at my agency are well integrated – the persons I serve receive mental health treatment without barriers or challenges.				
x	When persons receiving case management services at my agency experience psychiatric or behavioral crises, our agency provides timely, effective intervention to keep the people we serve safe.				
y	State hospitals and training centers have clear roles and are resources for persons with mental retardation who experience psychiatric or behavioral crises.				
z	Most of the persons I serve enjoy social opportunities, friendships, and relationships with persons other than their family or persons paid to work with them..				
aa	I have serious concerns about some of the residences in which some of the persons I serve are living.				

7 Are the persons you serve able to access the following services adequately?

	Services or Issues	**Agree**	**Disagree**
a	Persons have access to safe, affordable housing of their choice.		
b	Persons receive adequate service planning, linkage, and coordination.		
c	Persons have access to needed job training, job support, or jobs.		
d	Case management services are promptly available for new persons to our system.		
e	Consumer' rights and privacy are protected at my agency.		

f	Persons receive adequate opportunity for choice in the services they receive in our community.		
g	The persons I serve can call me – or another case manager or supervisor covering for me - during evenings or weekends (not for emergency services).		
h	Persons who are new to case management services (or their authorized representative) are able to choose who they want to be their case manager.		
i	Persons who are receiving case management services are allowed to change to other case managers without delay or impediment.		
j	Persons who are receiving case management services and who move to residential services outside our CSB's catchment area are offered the choice of case management CSBs.		
k	Persons have access to a psychiatrist when they want or need to, without undue waiting.		
l	Persons have access to appropriate outpatient therapy services if they want and need it.		

8 Which of these choices best describes how most persons' plans and goals (CSP) are developed.

		Pick only one.
a	Case manager develops individual services plan (CSP) for the person and explains it to the person and family or AR.	
b	Case manager involves persons and their families or ARs in developing their CSP, inviting the person to share in creating goals.	
c	Persons served and their families or ARs substantially lead the development of their own need assessment and CSP, in their own words, with case manager supports.	

		Yes	**No**
9	Are there any differences about the services you provide to persons who are eligible for Medicaid Targeted Case Management and those who are not?		
a	If yes, please describe differences:		

10	What do you like most about your job?	
11	What do you like least about your job?	
12	When things get really busy and competing demands mean something must be given up, what case management services are most likely to suffer, to not get as much attention as you would wish to give?	
13	Does the name “case management?” accurately describe the services you provide for consumers? What would be a better name?	
14	What one or two changes do you think are most needed to improve case management services in Virginia?	
a		
b		

Office of the Inspector General
Survey of Adult Mental Retardation Case Management Services – May 2007

Instructions:

Read through the entire form first to avoid duplication of effort and ensure consistency of totals. Please complete one form for each CSB, combining data for all sites or locations where adult mental retardation case management is offered, including staff that provide case management as part of other duties or as part of a multi-disciplinary teams. Include full and part time mental retardation case managers. Do not include children's, mental health, or substance abuse case management: This form is designed in MS Word for you to complete and send in as an email attachment. Simply type your data in the boxes (they will expand to contain your content), then save as a Word document when you have finished. Attach that saved file and return it by email to the OIG. If you prefer, you may print the form and fax it to 804-786-3400.

Email to: pat.pettie@oig.virginia.gov

If you have any questions about how to complete the survey, please contact John Pezzoli at 804-432-4285 or by email at john.pezzoli@oig.virginia.gov.

Please complete the survey and return it by May 30, 2007.

Name of CSB	
Contact person about this form	
Title	
Telephone	
Email address	

1.	How many adults with mental retardation are in service (all services, not just case management) at your CSB/BHA currently?	
2.	Of this number, how many persons are receiving adult mental retardation case management currently?	

3.	What is the entry-level salary for adult mental retardation mental retardation case managers at your CSB?	
4.	What is the average current salary for adult mental retardation mental retardation case managers at your CSB now?	
5.	How many of your mental retardation case managers are also nurses (e.g., LPN, RN, MSN)?	
6.	How many of your mental retardation case managers are licensed (e.g., LCSW, LPC, Clinical Psychologist, MSN-CS)?	
7.	How many of your mental retardation case managers have a master's degree, but are not licensed?	
8.	How many of your mental retardation case managers have a bachelor's degree?	
9.	How many of your mental retardation case managers have less than a bachelor's degree?	

We are interested in understanding your CSB's model or approach to case management for adults with mental retardation. Please describe your approach to case management by addressing the following questions.

10.	How does your CSB determine eligibility for adult mental retardation case management at your CSB? Who is admitted?	
11.	Do you operate levels or tiers of case management? (e.g., persons with greater needs get more intense services, such as TCM, those with fewer needs get a less intense level, such as Inactive/Monitoring). If yes, please describe the tiers or levels and how they are different.	

12. Do you establish caseload limits? (staff to consumer ratios)? Are these based on levels of need/service? (e.g., 1:25 for TCM, 1:75 for "Inactive/ Monitoring" "we limit all mental retardation case managers to 60 cases, but it is a heterogeneous mix of levels of need and services," etc.) If you have such standards, please state them here.	
13. How long is the wait from first call or referral of a new client to the agency to the first meeting with the person's new case manager (Active case management)?	
14. Do you have a waiting list for adult mental retardation case management services? If so, how many are on it, what is the average waiting time to get active case management service?	
15. If a person receiving case management services needs to be seen by a psychiatrist, how long is the wait from making the referral to first appointment with a psychiatrist?	
16. Do you assign case managers to persons from your CSB who are being served at one of Virginia's state training centers? To what status or tier of case management?	
17. If you assign case managers to residents at training centers, what is the expected level of activity? Do you expect that the CM will attend the residents Service Planning Meetings?	
18. How many more mental retardation case managers do you estimate you would need to provide an adequate level of active service to all adults with mental retardation, regardless of their funding eligibility? This means adequate caseloads, fully meet persons' case management needs, no wait for services, no one denied service, etc.	
19. What training is provided by your agency for all mental retardation mental retardation case managers? List training programs that are mandated by your CSB/BHA *for mental retardation case managers* (only training specific to mental retardation issues and case management – do not include standard training and orientation provided to all new employees, such as human rights, OSHA, etc.):	

20. What one or two things would you suggest that would improve the provision of adult mental retardation case management?	
21. Are your adult case management services part of an integrated team of case managers – the team provides both mental retardation and mental health or substance abuse case management? If this varies among sites (e.g., rural offices combine roles, but the main site does not), please explain where relevant. • In the same team or unit, but by specialty (individuals are either MH or MR or SA specialists)? • Individual case managers provide more than one type of case management, e.g., MH and MR? Note which combinations occur, if any.	
22. To what position does your supervisor or manager(s) of case management report (e.g., Mental Retardation Services Director, Executive Director, other). Please explain.	

CASE MANAGEMENT STAFFING.
Please respond for all adult mental retardation case managers, full or part time. Do not include children's, mental health, or substance abuse case management. If your case management services are integrated (e.g., MH/MR) estimate the portion of time each person spends on MR case management.
List staff – This is a Word table; you may add rows to table as needed.

23. **Case Management Staffing:**

Case Managers (Names)	**% time this C.M. assigned to case management**	**# years this C.M. has been employed in this position**	**# of persons for whom this C.M. is the principal provider of Active C.M. services**	**# of persons in this caseload who receive Medicaid Waiver funding and TCM**	**# of persons in this caseload who are not funded by Medicaid TCM**	**# of persons in this caseload who receive Inactive or Monitoring C.M.**
Total (for column 1, total to FTEs, e.g., 14.75 FTEs, for column 2 compute average years of service) →						

These questions address your CSB/BHA's experience in meeting case management staffing needs:

Yes No

24. We have significant barriers to recruitment and retention of qualified mental retardation case managers.

If yes, list barriers:

	Yes	No
25. Case manager tenure in their positions is sufficiently long to assure continuity in relationships with the consumers we serve.		

Thank you for completing this survey.

Office of the Inspector General Assembly
Mental Retardation Case Management Review
Family/Residential Provider Interview

Person Served: _____
Case Management CSB: _____
Case Manager: _____

Date: _____Respondent:_____

Role (circle one): AR family member Residential Provider

Name of Provider Organization: _____
Public? _____ Private? _____

Question	Comment	Ratings
1. How often do you have face-to-face contact with (the case manager)?		1 – weekly 2 – monthly 3 – a few times a year 4 – less than once a year 5 – no contact
2. How often on average do you have some other form of contact (phone call, email, letter) from (the case manager)?		1 – weekly 2 – monthly 3 – a few times a year 4 – less than once a year 5 – no contact
3. Where do the majority of the face-to-face meetings with (the case manager) take place?		1 - his or her office 2 - the day support program 3 - the home of the person served 4-other

		5-no meetings
4. Overall, are you satisfied with the services and supports that (the case manager) provides to (the person served)?		1 – yes/mostly 2 – somewhat 3 – no, not at all 4 – don't know
5. Overall, are you satisfied with the services and supports that (the case manager) provides to ***you*** (the family or residence)?		1 – yes/mostly 2 – somewhat 3 – no, not at all 4 – don't know
6. Has turnover of case managers (staff coming and going) been a problem?		1 – yes/mostly 2 – somewhat 3 – no, not at all 4 – don't know
7. Do you have adequate participation in and communication with the case manager about _____'s plans and services?		1 – yes/mostly 2 – somewhat 3 – no, not at all 4 – don't know
8. Do you think that _____ gets enough say in developing his/her own plans and activities with the case manager?		1 – yes/mostly 2 – somewhat 3 – no, not at all 4 – don't know

9. For families: Do you feel that you and _____ had adequate choice among residential providers or homes for _____?		1 – yes/mostly 2 – not really, little choice offered. 3 – choice limited by providers/vacancies 4 – don't know
10. For residential programs: Do you feel the case manager afforded _____ adequate choice among residential providers or homes?		1 – yes/mostly 2 – not really, little choice offered. 3 – choice limited by providers/vacancies 4 – don't know
11. Does (the case manager) treat (the person served) with respect, dignity, and courtesy.		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know 5 – Does not apply
12. If there is one thing you would change about the case management service _____ is receiving, what would it be?		